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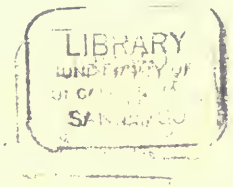
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WAR-SHOCK

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LONDON: WILLIAM HEINEMANN

WAR-SHOCK

THE PSYCHO-NEUROSES IN WAR
PSYCHOLOGY AND TREATMENT

By

M. D. EDER,

B.Sc. Lond., M.R.C.S., L.R.C.P. Lond.

Late Temporary Captain R.A.M.C., and Medical Officer in charge of Psycho-Neurological Department, Malta

feriuntque summos
Fulgura montes.

LONDON
WILLIAM HEINEMANN

London: William Heinemann, 1907

PREFACE

As the material for this book I have taken the first hundred consecutive cases of psycho-neurosis which came under my care; the psychoses have been excluded. A certain number of these hundred patients were admitted into the general surgical and medical wards of which I had charge in the earlier stages of the Gallipoli campaign; the larger number were patients who were sent into the special department which was formed later on and entrusted to me. By limiting the detailed observations to a small number of patients, who, however, present collectively the chief varieties in the symptoms and psycho-pathology of war-shock, a better basis is secured for the understanding of this condition than could be obtained by a more general account of larger numbers.

No claim is made for regarding the figures given in this book as of universal validity. In medicine, perhaps especially in psychological medicine, mere statistics are, I believe, of little value, and are more prone to occasion erroneous deductions than the detailed records of a few cases.

The appendix (pp. 146-152) gives a summary of the ætiology, symptoms and results of treatment of these first hundred patients.

Through the friendly interest in the work taken by my commanding officer, Lt.-Col. Scanlan, R.A.M.C., and the ever willing co-operation of the nursing staff, I was

able to live with these patients for hours and days together ; it was possible to make a fairly intensive study of their difficulties and troubles.

To many of my one-time colleagues in the Malta Command I am indebted for help in securing the well-being of the patients : to them my thanks. More especially to Surgeon-General Whitehead, A.M.S., who sanctioned the creation of the special department, and to Col. Purves Stewart, Consulting Physician to the Malta Command. Col. Stewart saw most of the patients before they came into the department ; he took the liveliest interest in their progress, and was ever generous in allowing me to have his earlier records of the cases. My friend, Dr. H. Wingfield, I must thank for his kindness in reading through the proof sheets.

This book does not pretend to deal exhaustively with the ultimate concepts of the psycho-neuroses. I have had in mind two considerations : to give so much of the psychology as to make the symptoms intelligible, and to show that soldiers suffering from war-shock respond peculiarly well to psycho-therapeutic treatment. It offends the scientifically trained mind to read, as I did to-day : "A soldier, who became dumb two years ago after an explosion, suddenly recovered his speech at a cinematograph show."

It is not necessary that a soldier's cure should have to depend upon the chance stimulation of his emotions at some greater or lesser interval after his injury. Medical science can to-day reduce this period of misery and suffering to a few days in the vast majority of soldiers afflicted by shell-shock.

The book was planned and mostly written whilst on service, a condition which prevented any attempt at a critical study of the literature. This cannot be made till the war is ended. I have preferred to have this book

published during the war in the hope that my experiences may be useful to others, may assuage, in howsoever small a degree, the sufferings* of that most splendid, cheery and heroic figure, the British soldier, none other than the common Briton—the working man whose very same virtues we too often fail to recognise without the khaki.

M. D. EDER.

* Since this was written the following is one of several similar cases that have come under my notice:—A clerk, aged 26, enlisted at the beginning of the war. After several months in the trenches he got shell-shock; tried to carry on for some days, but was then ordered to hospital. He remained in a hospital and a camp for nearly ten months without any improvement. He was then discharged from the Army with a gratuity of £20. Believing himself now given up by the doctors as incurable, and thinking that he would never support himself, he grew more despondent than ever. When some weeks later he came under my notice he was suffering from exhaustion, confusion of ideas, causeless terrors, want of concentration, so that he could not read or write a few lines or add a couple of figures. He was being supported by his friends and relatives. A few weeks treatment restored him to the normal and put him in a position to earn a livelihood.

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CHAPTER I

INTRODUCTION

THE institutes of medicine remain unshaken by the war. It has, however, raised many new medical questions, thrown fresh light on old problems, and demanded the application of the ancient principles under novel conditions.

The war has apparently created some new diseases: we read of trench-fever, trench-nephritis, and so on. In the sphere of the psycho-neuroses no new diseases are to be discovered. Oppenheim has, it is true, written a book upon them,[1] but his new diseases—reflex paralysis, akinesia amnestica—seem but due to his ignorance of contemporary psycho-pathological work. His German critics, Birnbaum, Lewandowsky, and others, have sufficiently dealt with his claims. (See the discussion at the *Berliner Gesellschaft für Psychiatrie*, in the *Zeitschrift für die gesamte Neurologie und Psychiatrie*. (Bd. 12, Heft. 4, 1916, p. 427.))

But though no new diseases have been produced by the war, we have learnt much that is new about the old diseases, and obtained new evidence confirming earlier views. We have learnt that a psycho-neurosis can be produced by stress of external conditions, acting on a mind which is but a degree or so more sensitive than the normal person's—a sensitive-

1 "Die Neurosen nach Kriegsverletzungen.

ness which should have involved no disability in normal life, rather the contrary—it might tend to success in a man's particular vocation, or make an artisan take a lead in the affairs of his own trade, or parish affairs, or enter Parliament. This psychoneurosis is what I call *War-shock*.

It is to these conditions that Grasset[2] refers as presenting "la forme classique de l'ancienne hémiplegie hystérique."

Though the form is the same, there is a difference in kind; in war-shock the external psychic factor is overwhelmingly greater than the second factor—the predisposition.

This view is also maintained by Benon,[3] who writes: "L'importance attachée pratiquement aujourd'hui à la prédisposition ou mieux aux causes prédisposantes est tout à fait excessive."

We also find among soldiers suffering from the same symptoms cases which correspond to the psychoneuroses more commonly seen in civil life. These I call here non-war-shock cases.

The aim of this little book is essentially a practical one; it is hoped to give an understanding of the mental processes at work in these affections, so as to provide the sound basis for their adequate treatment. Professor Elliot Smith in a valuable paper[4] writes: "Everyone who has had any dealings with the patients in the military hospitals scattered throughout this country must admit that much more might be done for patients suffering from some of the protean manifestations of shock than is being attempted at present. . . . Such patients may recover of them-

2 "Les psychonévroses de guerre": Presse Medicale, 1915, p. 105.

3 "Les maladies mentales et nerveuses et la guerre."—R. Benon. *Revue Neurologique*, Février 1916. No. 2, p. 215.

4 "Shock and the Soldier." The *Lancet*, April 15 and 22, 1916, p. 813.

selves without any attention, but a large number of them tend to get worse, and if they are left without attention their symptoms are apt to become stereotyped into definite delusions and hallucinations."

There is no reason why this should be. The symptoms respond to treatment quite as readily as surgical or infectious affections; nor, in the majority of cases, need the active treatment be very prolonged.

My earlier nerve cases had to be picked out from the heterogeneous diseases, mostly surgical, admitted to my wards: *e.g.*, in the very first batch of patients admitted to my wards the day our hospital was opened, June 10th, 1915, was a hysterical deaf-mute. I am thus enabled to confirm from personal experience the statements of others that functional diseases are rare among the wounded. I cannot go so far as Wiltshire, who claims that "Shell-shock is not to be seen in surgical wards," *i.e.* "as exemplified by monoplegias, paraplegias, mutism, somnambulism, fits, hysterical fits, and neurasthenia"[5]: out of 150 cases only 14 had been wounded.

Horstmann[6] has seen no functional diseases among the wounded, whilst Nonne[7] says they are very rare. Rothmann[8] and Oppenheim,[9] on the other hand, say that functional diseases are very frequently associated with organic lesions.

The following table shows in 100 consecutive cases (the psychoses have been excluded) the relationship between surgical injury, shell-shock and functional disease.

5 Harold Wiltshire. "A Contribution to the Etiology of Shell-Shock." *Lancet*, June 17, 1916. p. 1207.

6 Quoted *Zeitschrift fur die gesamte Neurologie u. Psychiatrie*, April, 1915, Bd. 11, Hf. 5, p. 344.

7 *Ibid*, p. 344.

8 *Ibid.* p. 345.

9 "Zur Kriegsneurologie." *Berliner klinische Wochenschrift*, 1914. No. 48.

Without previous injury, shell-shock, etc....	53
Following shell-shock	19
Associated with injury such as wound, fall, etc. (frost-bite in two cases)	28
	100

Shell-shock has been given prominence on account of its prevalence and the various hysterical symptoms that have followed the high explosions. Exactly the same symptoms have occurred, however, after shrapnel wounds, falls, and without previous injury at all. We take note of shell-shock in the ætiology, but to make it into an independent disease (apart from practical convenience) is about as valuable as it would be to regard enteric fever arising from drinking polluted water as a different disease from enteric fever arising from drinking polluted milk.

The view that mere chemical poisoning is the causative agent in shell-shock has nothing to recommend it. Suggestion in any form, whether the patient is awake or under hypnosis, could not remove the poison, but it may immediately relieve the symptoms. In what way shell-shock or poison, as auto-mimicry, is a contributing factor is pointed out later on (p. 48). And from that point of view the shell-shock may be said to be the causal agent: that is to say, had there been no shell there would be no concussion and no subsequent hysterical mimicry of that concussion; but equally of course, if we trace the sequence further back, we should say if there had been no war, etc., or if the Kaiser . . . . and so on *ad infinitum*.

We agree with Grasset[1] that it is "la présence et la prédominance de l'élément psychique" upon which the emphasis should be laid in these affections;

1 *Loc. cit.* p. 105.

hence the term psycho-neurosis. Wiltshire[2] concludes that "any psychic shock or strain may cause a functional neurosis, provided it be of sufficient intensity relative to the nerve resistance of the individual. Such shock or strain need not have any connection with "sex complexes."

The term functional disease is a very good one if it be understood that we have primarily an interference with function, which may or may not produce secondarily a structural change. This is in sharp contrast with the organic diseases where the primary lesion is structural, the interference with function being secondary. A fracture of the femur interferes with the function of the leg, a wound of the musculo-spiral nerve interferes with the function of the hand, but the interference with function is consequent on the structural changes. In a hysterical paralysis of the leg, in hysterical wrist-drop, no primary organic lesion, macroscopic, microscopic, muscular, or bio-chemical, need be postulated. We can account for these conditions by psychological laws. In doing so we must exclude altogether physical terms, brain-cells, movements of dendrites and the like. This is not the place to examine, as I hope to do in another book, the relationship between mind and body placed by recent psychological work upon a more scientific footing; it must be sufficient to say that against the very current dogma that disease is inconceivable without some underlying physical basis, the dogma in this little book is that some diseases are conceivable without any underlying physical basis; *mens peccat, non corpus.* The evidence for this statement will be found in the psycho-pathology of the diseases which are treated (Chapters III, IV and V). To prevent misunderstanding the corollary

2 *Loc. cit.* p. 1, 212.

may be added that some diseases are inconceivable without an organic basis.

The dogma at the back of this book does not stand upon the fashionable doctrine (less fashionable to-day) of a psycho-physical parallelism. The use of terms such as region of the mind, passing into the unconscious, and so on, which would imply that the mind is extended, are to be regarded as figurative; I could not omit these terms without troublesome paraphrases and a full explanation of the doctrine that the mind has relationship to time, whilst matter (here as brain and nervous system) is related to space.

Though the influence of mental processes upon the body will be the chief study, the action of physical processes upon the mind will receive notice. Every physician is, of course, acquainted with and makes use of these reciprocal actions in a general way. We all know that cheerful surroundings and sympathetic understanding can occasionally convert physical illness "from a consuming fire into a gentle licking flame, and make it thus expire."

We must also recognise that physical means have sometimes a no less valuable effect upon mental states; Lord Byron was not singular in finding a dose of salts to be the most exhilarating stimulant in moods of depression.

The diseases here considered are hysteria and psychasthenia. I have excluded the term neurasthenia altogether, because I am unable to find, at any rate in the troubles produced in the war, any clinical entity that corresponds to this term. Beard, who baptised this disease, defined neurasthenia as a "chronic, functional disease of the nervous system, the basis of which is impoverishment of nervous force, waste of nerve tissue in excess of repair; hence the lack of inhibitory or contributory power—physi-

cal and mental—the feebleness and *instability* of nerve action and the excessive sensitiveness and irritability local and general, direct and reflex."[3] It is not any stickling for etymological rectitude that gives rise to an objection to the term. It is the impossibility of apprehending the disease. Beard already included in his book a mass of symptoms, obsessions, phobias, hysterical manifestations, to which later writers have added. Neurasthenia is now frequently an euphemism for insanity in a patient where for some reason or other the word insanity must not be or is not mentioned; it is not without its danger when thus used. In colloquial usage, much as the laity speak of a nervous breakdown, or of rheumatism, or a touch of the gout, or a chill on the liver, the word no doubt will continue to find useful employment.

Freud[4] has dealt with the difficulty by giving the name neurasthenia to the following syndrome: exhaustion, mental and physical; depression, pressure on the head, spinal irritation, and dyspepsia. "According to Freud's views this clinical picture corresponds to the specific cause of excessive masturbation or frequent pollutions, or better expressed, neurasthenia [as thus limited] may in every case be traced back to a condition of the nervous system which has been acquired through excessive masturbation or arisen spontaneously from frequent pollutions."[5]

I have not found this simple syndrome among soldiers; not, of course, that masturbation does not

3 "A Practical Treatise on Nervous Exhaustion (Neurasthenia)," by G. M. Beard, A.M., M.D. New York; Second Edition, 1880, p. 115. His first paper with the term neurasthenia was published in 1869, in the *Boston Medical and Surgical Journal*.

4 "Neurosenlehre. Sammlung kleiner Schriften," Vol. I. 1893-1906. Leipzig and Vienna: Deuticke.

5 "Freud's Theories of the Neuroses," by Dr. E. Hitschmann, translated by Dr. C. R. Payne. New York, 1913, p. 15.

occur among them; many of them are at the adolescent age when masturbation is common enough, and I have had, of course, soldiers addicted to masturbation or complaining of frequent pollutions. But it has not in them given rise to neurasthenia as thus defined. Case 100 (see p. 100) would at first sight seem to be an instance of this, since the only symptom for which he was sent into hospital was exquisite fatigue; but psycho-analysis revealed a very different picture from that given by Freud. I do not, of course, suggest that Freud's neurasthenia does not exist, only that I have not come across it among soldiers. Freud split off from Beard's neurasthenia another group of symptoms, the anxiety-neurosis. This again I have not found in its pure state among soldiers, whilst his other clinical picture of anxiety-hysteria is common.

I have followed Freud in dividing hysteria into two groups.

A. *Conversion-hysteria*, which includes the affections of the senses and locomotion, fits, and so on. Here the mental affection is converted into its physical equivalent.

B. *Anxiety-hysteria*, where the condition of dread, anxiety, fear, is the prominent symptom and is due to some repressed unconscious mental complex. The association of this condition with vaso-motor and other symptoms is dealt with in Chapter IV.

Psychasthenia, which to some extent corresponds to Freud's obsessional neurosis (Zwangsneurose), is the other psycho-neurosis which is found among soldiers; clinically the cases correspond very well to Janet's[6] description: "Les psychasthéniques . . . présentent un abaissement de la conscience dans sa totalité . . . Cet abaissement général qui n'est pas com-

6 Pierre Janet. "Les Obsessions et la Psychasthénie." Vol. I., p. 675. Alcan: Paris, 1903.

pensé par un rétrécissement du champ de la conscience leur donne des sentiments d'incomplétude bien plus accentués qu'ils ne sont d'ordinaire dans l'hystérie." Obsessions, imperious acts, phobias and various physical stigmata characterise the psychasthenic.

On the above classification my 100 cases show:

Conversion-Hysteria ...	77
Anxiety-Hysteria	17
Psychasthenia	6
	100

Most of the cases in the group of anxiety-hysteria correspond to cases included by Janet among his psychasthenics.

This book does not treat of the psychoses as found among soldiers. Having had charge of a mental ward in connection with the psycho-neurological department, some investigations were able to be made into the psychology of their insanities, although the patients were with me for too short a time to obtain any complete knowledge; the treatment was necessarily unsatisfactory because our hospital was not fitted out for mental patients, and the patients were transferred to England at the earliest opportunity. Despite these limitations, I feel justified in saying that a considerable number of the psychoses occurring in the war, first attacks with a good psychological history, bid fair to become entirely well under proper treatment.

I have not seen any statistics as to the number of psychoses in our armies; it may be of interest to mention that Alt[7] estimates them at 1/1000 in the German Army. Hoche,[8] on the basis of previous

7 *Zeitschrift f. die. g. Neur. und Psychatrie*, Bd. 12, Heft. 1, p. 8.

8 *Ibid.* Bd. 11. Heft. 5. p. 330.

experiences in German wars, places the insane to be about 2/1000, and thus in an army of $4\frac{1}{2}$ millions he says there would be about 8-10,000 insane.

Jung has divided the psycho-neuroses into (*a*) diseases of extraversion (hysteria) and (*b*) diseases of introversion. I have been tempted to follow him, but my analysis of many of the cases was not fundamental enough to venture here on this difficult path. A broad psychological distinction between hysteria and psychasthenia can, however, be made; if with Freud we may say that the hysteric suffers from his past, the psychasthenic suffers from his future.

Each forward step, babyhood to childhood, childhood to puberty, puberty to adolescence, is fraught with difficulties for the psychasthenic; he cannot fit himself into the real world which his unconscious self has already foreshadowed. However clear and urgent is the need for adapting himself to the situation which his mental and physical growth demand, when it comes to execution his mind becomes inert. To avoid the difficulties which loom so tremendous, his mind busies itself in the creation of phantasies centering round the past. If we have on the one hand the creative impulse in man which transcends his experiences, we have on the other hand what we may call creation (libido) in opposition, *i. e.*, contentment with the present, basking in the sun, sloth—the deadliest of the seven deadly sins. This mind will form a thousand difficulties and obstacles to its onward path, difficulties and obstacles which will never be ascribed to this inertia, but will be invariably put down to the doings of other persons or to troubles arising from the real world. It is discovered that

> "Shades of the prison house begin to close
> About the growing boy."

This prison house becomes the incest motif, the

"terrible mother,"[9] the temptress, the serpent; the fear of the father. The child has gradually to wean itself from the warm family life, once a necessity for its very existence, to acquire spiritual autonomy, just as it has had to gain physical independence.

This book does not deal with the more fundamental problems of the psycho-neuroses and the relationship of these affections to more normal lives. In only six cases was psycho-analysis, the only method with which I am acquainted that lays bare the innermost secrets, carried out for therapeutic purposes. That is to say, in only six cases did the patient learn to make the diagnosis of his condition, to realise himself in any measure, to arrive at an understanding of his unconscious complexes and conflicts. Nor was the treatment complete in any of these six; the necessities of military medicine did not permit me to keep the patients long enough under my care in Malta for this. For professional, not scientific, reasons some of these cases are not published. In the other cases I have been content to find the psychological explanation of the mechanism of the symptoms.[1] This could be done by a close personal relationship with the patients, allowing them to talk at their ease, asking few questions, but gathering their life-history, earlier characteristics, their dreams past and present, the details of their symptoms, and their mental and physical condition, both at the time when the disease occurred and subsequently. The interpretation of the knowledge thus acquired has been made by the results of that

9 See "The dual mother rôle" in Jung's "Psychology of the Unconscious," translated by Dr. B. M. Hinkle. New York: Moffat, Yard & Co., 1916.

1 This explains the omission of the full history of No 81, who had a fairly complete treatment by psycho-analysis with excellent result. I was able to keep this patient under observation several months after the end of his treatment.

psycho-analytic work which we owe to the genius of Freud.

So far as these 100 cases of psycho-neuroses in war are concerned, it will be seen that sex is not the only factor. Sex is often, to use one of Freud's terms, a "Deck-Erinnerung," a "cover-memory" to conceal something more momentous. See the analysis of cases Nos. 99 and 100, pp. 100-114 But in some cases sex, in the form of the typical Œdipus myth, is very clearly brought out (No. 26, p. 74), whilst in other cases it was highly probable that adequate psycho-analysis would have laid bare a sexual complex which again would have shown to be itself symbolic of the individual's mal-adaptation. The method of interpretation upon which I had to rely cannot bring these deeper complexes and ultimate aims to light. The deeper layers of conflicts do not emerge into the conscious until the more superficial complexes have been dealt with by consciousness.

Nor is it just funk, as one neurologist calls it, that gives rise to functional diseases; the part that suppressed fear may play in the production of hysteria will be considered later, but this is quite another thing. Among the many mutes I have seen it is rare to find one who was struck speechless by terror. But terror is not funk, or fear.

A few instances of sex perversions have been encountered, but none happens to be included in the first 100 cases. I have no evidence to confirm a statement made by Touton[2] that war exercises an important influence upon the sexual life in its various phases, both inhibiting and stimulating it;

2 Geschlechtsleben und Geschlechtskrankheiten in den Heeren im Krieg und Friede. Berliner klinische Wochenschrift, Nos. 1—4. 1915.

occasionally there is a pathological increase even to the production of perverse sexual tendencies and actions. He says that the stage of long marches and battles and the trenches offer no inducement for sex-action, but during camp life, and especially after the occupation of large cities, there is abundant opportunity. Juliusberger [3] finds that certain cases of absence of love of the fatherland, absence of interest in the war, and want of understanding about the war, are due to a pathological sexual infantility.

As careful an investigation as the circumstances permitted has been made into the family and personal antecedents of the patients. Whenever there has been the slightest evidence of a bad family history or of earlier psycho-neurotic trouble, quite apart from any actual illness or "break-down," discerned either in the preliminary case-taking or in the later psychological enquiry, the case has been set down as having pre-war antecedents. It is to be noted that all the cases of psychasthenia had an *antebellum* history. The analysis shows :—

With pre-war history (family or personal)	30
Without ,, ,, (=war-shock) ...	70

These figures contrast very strongly with those given by other observers. Laudenheimer,[4] for instance, says that out of 52 cases of psycho-neurosis there was in 90 per cent. a predisposition either by congenital constitution or by disease acquired before the war. Forsyth [5] has found, "In all cases coming under the writer's notice with symptoms which were more than mild and transitory a history of some

3 Zur Kenntniss der Kriegsneurosen, Monat. f. Psych. u. Neurologie, 38, No. 15, 1915.

4 Münch. med. Wochenschrift, No. 38. 1915.

5 "Functional Nerve Disease and the Shock of Battle." David Forsyth ; *Lancet*, Dec. 25th, 1915, p. 1401.

earlier nervous trouble, slight or severe, was forthcoming."

Mott[6] says, that "in a certain proportion a little more than one-third, the cumulative effects of stress of active service, combined with repeated and prolonged exposure to shell fire or high explosive projectiles, apparently had induced a neurasthenic or hysteric condition in the nervous system of a potentially sound individual."

Mott's conclusions are for cases of shell-shock only. Taking for comparison the 19 cases of shell-shock alone out of my 100 cases the following figures are obtained:—

With previous pre-war history (family or personal)	8
Without any ,, ,, ,,	11

Moreover, the estimates given by Mott and Laudenheimer are based upon the anamnesis; a psychological examination, which begins when the anamnesis ends, brings to light neuropathic traits unsuspected and incapable of recognition by the methods used by those observers. My figures are based upon a psychological examination sufficient to bring out any latent neuropathic traits.

Harry Campbell[7] says that it is chiefly among the unstable nervous systems that the neuroses are met with in war.

On the other hand, and entirely in accordance with my own results, Elliot Smith[8] says: "It would be a gross misrepresentation of the facts of the case to label all the soldiers who suffer from mental troubles as weaklings. The strongest man when exposed to sufficiently intense and frequent stimuli may become

6 Transactions of the Royal Society of Medicine, February, 1916. Sections of Psychiatry and Neurology, p. 5.

7 *The Practitioner*, May, 1916.

8 Loc. cit., p. 855.

subject to mental derangement. It is quite common to find among the patients suffering from shock, senior non-commissioned officers, who have been in the army for fifteen or twenty years . . . and have stood this severe strain. Such men can hardly be called weaklings."

Nonne[9] admits that the hysterical syndrome is more easily aroused by adventitious factors than was thought. Mann[1] agrees that the healthy can become momentarily hysteric, and Hoche[2] contends that every combatant can become hysterical under appropriate experiences.

Grasset[3] is of the same opinion. "Les antécédents personnels *antebellum* et héréditaires ont relativement peu d'importance dans le développement des psychonévroses de guerre. Ma conclusion serait différente si j'avais à m'occuper des psychoses des guerres."

Those acquainted with the works of Freud and Jung will find nothing new in these statements which do but confirm the *antebellum* findings of psychoanalysis.

My own view, founded before I had been able to consult the war literature on the subject, was expressed in an address in April, 1916, to the Malta Medical Conference,[4] where the case of a patient suffering from hysteria consequent on severe fighting, for which he had been recommended for the V.C., was quoted:—

"In most cases the neurosis has arisen under the strain of quite extraordinary conditions. I would remind you that our Army is not composed of fighting men, in the technical sense. The men come from

9 Archiv. f. Psych. u. Nerv. 56, Heft. 1, 1915.
1 Deuts. Med. Wochenschrift, No. 4, 1915.
2 Archiv. f. Psych. u. Nervenheil, 56, Heft. 1, 1915.
3 Loc. cit., p. 107.
4 The Psycho-Pathology of the War Neuroses. *Lancet*, August 12, 1916, p. 168.

the mill, the mine, the farm, the counting house, the country house; every trade is represented and every class. Thus, men brought up to a quite other avocation are suddenly, with scant training, called upon to make a new adaptation. In the stress and strain of their normal life they would probably have been equal to any emergency. But for some—among the very best—the new conditions called out to them to strain themselves to the very utmost, and this was just a little too much. . . . Napoleon used to say that the British are a nation of lions led by asses. The lion is still there, and let me remind you lest, *post bellum*, you forget, that the lion is just our old friend, the British working man. Eighteen months ago the hero of the bayonet wounds (Case No. 24) was—a plumber!"

It should be remembered in connection with the comparative large number of well-seasoned N.C.O.'s who suffered from hysteria, that their responsibilities in this war have often been very great; that many are men who, having left the army after fine service, had married and settled down into good positions. Throwing up these, they have had the additional anxiety of feeling that at their time of life they may not be able, should their positions be lost, to find the same security for their families and themselves.

It should not be difficult to understand why hysterical shell-shock is rare among the seriously wounded. In these patients the psychical energy is sufficiently occupied with something very concrete and real; there is none to spare for the creation of phantasies and the conversion of these phantasies into the hysterical symptom.

In regard to the common statement that hysteria is a sign of degeneracy, and the statement, which was not made in Germany but by writers in this country who claimed to speak with authority, that the

English people are "a degenerate race," it is worth noting that 19 out of the 100 cases were Anzacs, and the majority of these 19 were not men from the cities but from the bush. Unless the relative proportions of the Anzacs to British troops employed on the Peninsula were known, no argument can be drawn from these figures. But one can say that the up country Anzac is not immune, in war anyway, from hysteria.

And this again is in accordance with the pre-war expectations of those who understood these conditions.

A psycho-neurosis occurs in two kinds of persons, those who are inherently below the level of the civilization, who may be called degenerates, but are more properly to be regarded as backwards, and those who are ethically in advance of their age. The latter are the harbingers of a new world, of the dawning civilization which may only (or may never) materialise centuries hence. Hence their conscious and unconscious selves are in constant conflict. It is the lot of the neurotic frequently to be in unstable equilibrium by reason of these inner conflicts. Such conflicts seem to be necessitated by the very essence of man. In so far as to-morrow will be like to-day, and it will be so in regard to a large number of mental processes, man is served by his experiences; but to man is given the gift not only of creating something in the morrow which is quite unlike to-day, dissimilar from his experiences, but also of foreshadowing that new creation. That forecast of the new he relates to his known experiences by means of symbols, with some of which we shall deal later.

The war might at least rescue the word neurotic from its present use as a term of reproach: without the neurotic the mind of man would be stationary. The war may teach those who have not already learned the lesson by what slightly graded steps

the normal differs from what we call the abnormal.

The following table shows the results of treatment:—

100 CASES.

Treatment.	Cured.	Improved.	No change.	Total.
Suggestion under hypnotism ...	70	7	2	79
Suggestion without hypnotism ...	3	2	—	5
Suggestion under anæsthetic ...	6	—	—	6
Psycho-analysis	1	4	—	5
Other methods	—	1	1	2
No treatment (referred for diagnosis, etc.)	—	—	[3]	3
	80	14	3 [6]	100

Thus out of 97 cases submitted to treatment, 80 were relieved altogether of their symptoms and 14 improved. What is meant exactly by cured and improved I shall discuss in the final chapter. These results were obtained under conditions which were not the most favourable for psychotherapy. The patients were 2,000 or more miles from home, they did not know whether they were to be sent back to the front or would go home first. Though everything possible was done in the way of entertainment by the residents of Malta, this island could not, of course, offer the many attractions arranged at home nor could our make-shift hospitals vie with the beauties and amenities of such places as Netley, or the 4th London General Hospital, where nerve patients are treated. The particular hospital where my patients were sent was regarded as an infectious hospital, and

the patients for some time were not allowed out of the limited hospital grounds. It speaks well for the patients, I think, that only three did not improve in their condition.

The next chapter, II, describes the clinical manifestations of conversion-hysteria; chapter III the psychological mechanisms of these phenomena. In chapter IV some cases of anxiety-hysteria are described and explained; chapter V deals with psychasthenia in the same way. The last chapters deal with the general diagnosis and treatment of these disorders.

CHAPTER II

CONVERSION-HYSTERIA

THE war has enabled us to see examples of almost all varieties of hysterical symptoms, varieties which, indeed, a special hospital would only be able to exhibit during the course of years. So protean are these symptoms that for the sake of easier following it becomes desirable to classify these manifestations according to the prominence of the symptoms.

A useful division is into

A. *Conversion-Hysteria* (Freud), where the somatic disturbance focusses the attention of the observer, and

B. *Anxiety-Hysteria*, where the psychical elements claim pre-eminence.

In both forms it need scarcely be said that physical and mental symptoms always co-exist, and that it is the mental state which demands explanation and requires treatment.

This chapter will be chiefly limited to describing the various somatic disturbances, leaving their psychological explanation, the psycho-pathology, to the next chapter.

SENSORY SYMPTOMS

My experience does not agree with that of Binswanger,[1] who says that pure sensory disturbances

1 Hysterosomatische Krankheitserscheinungen bei der Kriegshysterie. Monat. f. Psych. u. Neurol., 38 Heft. 1, 2, 1915.

were not found in true cases of war-shock (war hysteria); disturbances of sensation were always accompanied by motor disorders. I agree with Binswanger in his conclusion that the war hysteric is not, in the majority of cases, a constitutional hysteric. This conclusion is sound, but not so the premises; the following is a case where hyperæsthesia was the most prominent symptom.

No. 3.[2] A corporal, aged 37, who after 16 years in army service, had rejoined, and was wounded in May, 1915, in the right forearm, left nipple region, and elsewhere. The wounds were superficial and had apparently quite healed, but the site of the wound on the chest remained painful. Some months later the scar over the left chest reopened, and when it again healed the pain over the scar was so severe that he was unable to carry his equipment. When examined some eight months after the original injury he presented a scar 3½ in. long, running along the fifth intercostal space, with its inner end 2 in. from the sternum. The scar and the skin immediately adjacent were acutely tender to pressure—he could not bear the slightest touch here. To cotton wool touches, universal anæsthesia, save for a small area below inguinal folds on both sides, a patch 1 in. below and external to angle of left scapula. To pin pricks universal analgesia except (1) just below left scapula, (2) over scar and area 2 in. below it, (3) two small areas in lower abdominal region on a level with scrotum.

It will be seen that the anæsthesia and analgesia were almost complete and that the zone of hyperæsthesia was strictly limited to the area of scar.

Joint sense normal. Pupils normal. Smell normal. Hearing, contact L., Rt at 3″. Vibration sense lost in lower limbs, normal elsewhere. Reflexes: right

2 The numbers refer to the numbers in the appendix, p. 146 where a summary of the cases will be found.

plantar absent at toes and thighs (were present at a later examination); the left normal; abdominal reflexes, lower absent—the other reflexes normal.

There were no other symptoms; there was no other indication of disease of the nervous system. The scar and the skin adjacent were removed by operation in February, 1915; the wound healed by first intention. The operation did not alter the condition. The pain was still present, as were also the analgesia and anæsthesia. About a month later, ten months after the wound had been received, the patient was treated by suggestion under hypnotism. At the second sitting the symptoms entirely disappeared; the normal sensation returned in the analgesic area. For several days the corporal was rather dubious about the pain not returning, and he went through various manœuvres to assure himself that he was now all right. There had been no return when he left the hospital some time later.

General over-reaction and hyperæsthesia, following shell-shock, has been described by Myers[3] in a young stretcher bearer, when even the lightest touch of cotton wool on the limbs or head produced very little movement whilst a pin prick produced a series of most violent spasms, almost amounting to a convulsion.

Analgesia and anæsthesia are very common, though more frequently accompanied by functional motor disturbances. This is not invariable, as shown in the following case of *hemianæsthesia*. No. 1 was a powerful muscular man of 22, formerly a collier. There was complete left-sided hemianæsthesia, together with atrophy or absence of the subcutaneous tissues on the left side of the face, upper part of left chest, and the left limbs; possibly the metacarpal bones and phalanges of the left hand were

3 Charles S. Myers. The *Lancet*, March 18, 1916. Contributions to the Study of Shell-Shock. p. 608.

smaller than those of the right. There was no muscular wasting and no loss of power either in the left arm or leg. He had fractured the left forearm three years previously, and attributed the lessened size of the forearm to that accident. His attention was drawn to the much smaller size of the left wrist by a mate and he then became much alarmed, believing that he would lose all power. He was not aware, until examination in hospital, that other parts of the left side were also smaller than the right side.

A similar sensory condition was shown by No. 2, a corporal with over seven years' service, who was admitted for persistent headache which had lasted for nine months. He had been "gassed" in France, was three days unconscious, woke up with bad headache, and began to vomit "nasty green stuff." After three months he went back to the front, where he complained of pain in the chest and shortness of breath, "could not move without his head swinging round." He was at a rest camp for some time and then went to Salonica. The headache had never left him. A few days after his arrival at Salonica he went into hospital, and after a month was sent to Malta.

Examination showed a complete left-sided hemianalgesia, and a slight degree of simple myopic astigmatism (vision $\frac{6}{9}$ in both eyes without glasses). These and the headache were the only symptoms. Suggestion under hypnotism soon relieved the patient of his headache, the hemianalgesia disappearing rapidly, and the patient was in a few days sent to a convalescent camp. Four weeks later he was well and about to return to the front.

Both these patients were right-handed and the hemianæsthesia was, as is usual in functional diseases, on the left side.

More commonly the sensory is associated with

motor disturbance, as in the following case of *left hemiplegia and complete mutism.*

No. 21. An N.C.O., in the R.A.M.C., aged 36, who had seen 15 years' service. Four weeks before admission to Malta, whilst on duty at a hospital, he suddenly lost consciousness; on recovering he found he had lost power in the left arm and leg. Two weeks later, on admission to a hospital ship, he had another fit and on recovery found he had lost speech.

There was complete left hemianæsthesia, including the face, strictly limited to the middle line anteriorly and posteriorly.

The left visual field was contracted and there were loss of hearing, of smell, and taste on the left side. The tongue protruded to the left, but could be moved to the right at once on command. The reflexes were normal. The dumbness was absolute; the patient could not whisper, laugh or cough. But he heard and understood everything and could write perfectly.

It was considered advisable to relieve the symptoms of paralysis and mutism as soon as possible. The patient was therefore treated by suggestion under hypnotism a few hours after his admission to our department. Speech and normal sensation were recovered at once, and after a second treatment on the next day the free movement of the limbs was obtained. Naturally the patient, who was a highly intelligent man (he was about to get a commission), and had had a long experience in the R.A.M.C., had taken a very gloomy view of his condition. It would seem that the aphasia following the hemiplegia had been a little misleading, but of course the fact that the hemiplegia was left-sided and the patient right-handed told very much against an organic disease, for which one would have to suppose

a lesion of the right hemisphere of the brain, followed two weeks later by one of the left side.

The following instance of *total hemianœsthesia* occurred on the *right side* in a *left-handed* soldier. Its mode of development is of interest.

No. 24, a soldier aged 23, was with 23 men in a sap which was attacked by some 200 Turks. He and a sergeant leaped out of the trench and engaged in a hand-to-hand fight with the enemy who were eventually driven off. He received 15 bayonet wounds in the fight; seven of these were penetrating; 14 of the wounds were on the right side of the body. When examined one month later the wounds were all healed, but the fingers of the right hand were semi-flexed and could not be extended (claw-hand). Col. Purves Stewart had made the following note: to pin pricks anæsthesia-analgesia of the whole right upper limb as high as shoulder. At beginning of examination patient felt pin pricks at wrist, as examination continued the boundary of anæsthesia steadily receded until it reached the shoulder, by which time the previous sensitive spots were now anæsthetic; further examination showed a complete right-sided hemianæsthesia.

In another soldier, No. 19, aged 31, paresis of the left of the body, with complete left-sided hemianæsthesia, had followed an attack of dental neuralgia; he had been through the Gallipoli campaign without other injury than having the tip of a helmet taken off by a piece of shrapnel.

In a Welsh lad of 21, with loss of power in both legs, the anæsthesia and analgesia extended from toes to mid-thighs. (Case No. 10.)

In many cases the sensory affection is much more restricted; thus in a soldier, No. 23, with drop wrist of the left hand, which followed two days after receiv-

ing a slight gun-shot wound of the right hand, the loss of feeling and pain extended to 1 in. above the wrist. In another case, No. 22, with limitation of movements of elbow and inability to flex the fingers, the anæsthesia extended to 1 in. above the wrist.

HYSTERICAL CONTRACTURE OF KNEE.

No. 32, with 1½ years service; felt great pain in the back and in the right leg on the morning of November 29th, two days after the great storms in Gallipoli, where he was in the trenches and up to the chest in water. He was admitted to hospital on December 6th. The pains in the back gradually improved, but the knee grew worse—flexed, stiff, every movement being attended by great pain, *especially in flexion*. He was confined to bed and examined by the late Colonel Barker, A.M.S., under an anæsthetic, when no disease was found. [The increased pain on flexion was against the joint being tuberculous.] As his condition grew worse rather than better, he was sent for treatment, on January 30th, to the Psycho-Neurological Department: a skiagram was taken and showed an apparently normal healthy joint.

On the 31st January he was brought into deep hypnosis, when, under suggestion, he readily moved his knee in all directions. That afternoon, after waking, he felt no pain but still walked with the knee bent. The next day he was again hypnotised. After getting him to walk, I said (he was an Edinburgh lad in a Scotch regiment): "Now dance a Scotch reel." He stood stock still, not moving a muscle. I repeated the suggestion, but got no response. I then said: "Now waltz." He immediately gave a very creditable performance.

He was quite cured, no further treatment was necessary, he went to a convalescent camp and so to

the front. The explanation of his response to the waltz suggestion, and lack of response to the Scottish dance suggestion is that he had learnt how to waltz but not how to perform a reel; investigation showed also that his "local patriotism" was divided in allegiance, his mother being English, his father Scotch.

This experiment tends to show that the suggestion must be one to which the subject is not strenuously opposed, and helps us to understand why criminal suggestions are very rarely effective. If the criminal suggestion happens to coincide with a very strong wish, for the execution of which only courage has been lacking, it may be carried out, but if it is one which evokes opposition, the suggestion as a rule fails.

ASTASIA-ABASIA.

In other cases the motor symptom may exist or persist without any sensory disturbances, at least by the time the patient is examined.

No. 33. A corporal, of over 13 years' service, was riding along a mountain road when his horse backed and fell with him over the cliff. He probably dropped some five feet on to a ledge. He lost consciousness and awoke some hours later in a hospital. When seen five weeks later, sensation was everywhere normal. The grasp of the left hand was feeble. The legs could be moved whilst he lay in bed, but he could not walk or even stand without supporting himself (astasia-abasia). Treated by suggestion under light hypnosis, he was at once able to walk and quite recovered in two days.

DISORDERS OF SPEECH.

The most striking occurrence is complete loss of speech—mutism. This seems also to be the commonest

of the speech disorders. Out of my own 16 cases there were ten of mutism, three of aphasia, and three of stammering. This mutism may be associated with deafness (four out of ten), and may be quite complete. Mott says, "about one in twenty of those suffering with shell-shock and having no visible signs of injury have lost their speech, and yet are quite able on admission to write a lucid account of their experiences." [4]

That is to say, the patients cannot cough, whistle, make any sound when laughing, and in severe cases there is difficulty in putting out the tongue, and in one case of swallowing (Mott, *ibid*). They are able to express themselves well in writing, their reading is not affected. Sometimes they speak in their sleep or under an anæsthetic.

In several cases (six out of the ten) the mutism followed a shell explosion. A shell burst within a few feet of a young officer (No. 42); he did not lose consciousness but his speech went completely. Another soldier (No. 38) gave the following account: "My mate was killed a yard in front of me on August 7th; we had enlisted together and been together all the time. I was in the trench at the time. I lost my head that day and the sergeant had to stop me from going over the parapet. Three days later the accident occurred to me, a shell burst a couple of yards away. I lost consciousness. Some said afterwards that I was buried, others that I was shot upwards. I did not recover my consciousness till five days later, when I found myself on the ship going to Lemnos and unable to speak."

There need be neither shell-shock (*i.e.*, exposure to forces generated by high explosives), nor burial as a

4 Shell-shock without Visible Signs of Injury. Proceedings of the Royal Society of Medicine, Vol. IX., No. 4. Sections of Psychology and Neurology, p. xvi.

prominent factor. In No. 40, mutism followed a shrapnel wound of the leg; the wound was slight and soon healed, but the mutism remained and was cured by suggestion under hypnotism.

The right hemiplegic and mute R.A.M.C. N.C.O., already referred to (p. 24) presented the same absolute mutism as the shell-shock cases. In a private (No. 43), aged 21, the loss of speech occurred 36 hours after receiving a kick on the left lower jaw. He had been admitted to hospital, and was taking part in a sing-song, when he suddenly found he could not utter another sound; he remained dumb for three days, when, on awakening, he was able to whisper to the nurse to bring his breakfast. This case is discussed more fully in the next chapter.

An Australian, No. 37, had been mute and deaf for five weeks after two months' service in the Dardanelles; he had been in the support trenches and was of course under shell fire all the time, but had not himself been exposed to explosions in his immediate neighbourhood.

Sometimes the same symptoms have been present on some previous occasion. The young officer, for instance, had some months before, whilst on board ship, lost his voice for two hours; it then returned spontaneously. The mute who had been kicked had recurrent attacks after this first occasion; he became very excited playing cards one afternoon; he was winning and his speech left him. Another time he had become excited at church, went to bed in the ward feeling rather dizzy, and in the morning speech was quite gone. He would remain mute for one to four days.

No. 39, a soldier who was mute after a shell explosion, had been a miner. Eight years before there was an explosion which killed his brother working in the same mine, and he became mute, the condition being absolute for 15 months, when speech

partially returned. It took another three months to recover entirely.

APHONIA.

In some cases, instead of complete loss of speech, the patient is just able to whisper. In No. 44, this followed an explosion; he was blown some feet into the air by a shell but was not rendered unconscious. He then noticed that he could only whisper. In another case (No. 46), the only one of the kind that came under our observation, the condition arose during convalescence from typhoid fever.

STAMMERING

May be the primary speech defect in war-shock, or may follow mutism. (Cases of stammering before military service are excluded). In In a soldier, No. 47, of six years' service, stammering began after he had been invalided from France for gastric trouble; a year later he still stammered, and presented some vasomotor symptoms, tachycardia, and fine tremors of the hands. A younger brother (not in the army) was also a stammerer.

No. 48, an Australian, aged 21, was on board a ship that was torpedoed; he was not hurt but received a "mental shock." Fourteen days later, whilst in the trenches, he began to stammer. He had never stammered before; his mother and mother's brother stammered.

No. 25 was wounded by a bullet which entered ¾ in. to left of mid line behind, between D1-D2 spines; exit 2 in. external to left nipple and 1 in. above; after being shot he was first helped by a mate, then walked himself for half a mile. He lost consciousness and woke up the next day to find himself in hospital, with complete loss of speech and inability to use his right hand. He remained mute for four months, his speech then gradually began to recover and he went back to service; when examined

16 months later he stammered rather badly; there was paresis of the right hand with glove analgesia and anæsthesia. He could not use his fingers for delicate operations like shaving, buttoning, or putting the cartridges in the rifle. Under treatment the full power of the hand was soon restored, the patient announcing gleefully a few days after his admission that he had shaved himself for the first time for 16 months. The stammering, however, did not mend with corresponding rapidity.

Generally speaking, the apparently most serious speech defects are those most rapidly cured. Out of the ten cases of complete mutism nine responded immediately to treatment, as did one case of aphonia (No. 44), the other two cases of aphonia recovered 24 and 48 hours after treatment, whilst treatment effected far less for the stammerers; improvement occurred in one (No. 25), under treatment that quite cured the palsy of the hand.

It is interesting also that speech can be recovered despite the patient's conscious objection to treatment. In No. 39, where the disability was of six weeks' standing, all treatment was refused. He would not consent to hypnotism nor to being placed under an anæsthetic. He wrote that God had cured him without a doctor on the first occasion and he would prefer to wait for a natural cure this time also. It was pointed out that he had suffered 18 months on the earlier occasion, now he could get well in a few minutes. Finally he assented, but maintained that he was not expecting any help. He was lightly anæsthetized and suggestions were then made. He was hardly recovered from the anæsthetic when he asked the nurse in a whisper for a glass of water. In a couple of hours the voice was normal, but there remained hesitation in speech and loss of memory for some simple words. Suggestion under

hypnotism, carried out the next day with the patient's hearty consent, restored perfect speech.

WAR-AMBLYOPIA.

Loss of sight (the retinal anæsthesias of the older clinicians) may be partial or complete.

PERSISTENT AMBLYOPIA.

No. 55. In 1901, in South Africa, a pebble flung from a horse's hoof struck the right eye, and its vision has been defective since. He was discharged from the service. On the 6th May, 1915, at Hellas, a shell burst near him ; he was knocked down, but not unconscious. An hour later he vomited blood. He returned to duty. About the middle of June, 1915, the vision of the left eye began to be defective. This defect had progressed. On July 26th, 1916, examination showed : pupils equal and active ; eye movements normal ; tension in each eye normal.

$$\text{R V } \frac{6}{60} \text{ Hm} + 5.50 \text{ spl.} \qquad \text{L V } \frac{6}{36} \text{ Hm} + 5.50 \text{ spl.}$$

After homatropine and cocaine.

$$\text{R V c} + \frac{4.50 \text{ spl.}}{+ \overline{1.75 \text{ cyl. ex. } 20/}} = \frac{6}{60} \qquad \text{L V c} + \frac{4.00 \text{ spl. c}}{+ \overline{2.50 \text{ cyl. ex. } 10/}} = \frac{6}{36}$$

Fundi normal.

Fields of vision concentrically contracted, especially in the left eye. (Fig. 1, p. 34).

He was later on treated by suggestion under hypnotism ; treatment being at first directed mainly to the left eye. Ten days later the vision was

$$\text{R V } \frac{\div .3 \text{ c}}{+ \overline{1.75 \text{ ex. } 20}} = \frac{6}{18} \qquad \text{L V } \frac{+ 3.25 \text{ c}}{+ 1.50} \text{ ex } 10/ = \frac{.6}{12}$$

The visual fields were as shown in Fig. 2 [5] (p. 35)

[5] For the report and the perimeter charts I am indebted to Capt. A. D. Griffith, R.A.M.C. Specialist in Ophthalmology, Malta.

A feeble-minded lad,[6] who was wearing dark blue glasses, without which he said he could see nothing, I found reading small print in the dusk. His vision was R and L = $\frac{6}{24}$ with his own dark glasses; with neutral tinted glasses from the test case he could not see 6/60.

Probably more common than double amblyopia is unilateral amblyopia; I shall record later an interesting example of complete blindness in one eye coming on very suddenly whilst sniping. Sometimes the amblyopia is accompanied by photophobia and intense pain.

Diminished visual acuity is seen in quite a number of soldiers, sometimes without previous physical disorder, sometimes following injuries which may be slight, or such diseases as typhoid or dysentery. If these patients are not rapidly improving under the usual general treatment, suggestive therapy generally clears up the condition in two or three days.

No. 56 complained of bad sight and blurring of objects in October, 1915. Admitted later to Malta for "rheumatic pains in knees." Vision on December 29th, 1915, was R V = $\frac{6}{36}$ L V = $\frac{6}{24}$. He was sent to rest camp and re-examined on March 16th, 1916, R V = $\frac{6}{60}$ L V = $\frac{6}{36}$. Slight astigmatism not improved by glasses; fundi normal. After psychotherapeutic treatment, examination showed on March 19th, R V = $\frac{6}{24}$ L V = $\frac{6}{6}$. The right eye was amblyopic from disuse.

The hysterical symptoms were not, of course, always confined to the eyes. An Australian, No. 52, with amblyopia of the left eye was also paraplegic; he had hemianæsthesia of the left side of the body,

6 This case is not in the Appendix; it is not included in the 100 cases. He was under my charge in the mental ward which was quite separate. The "functional" patients were scattered among the general wards.

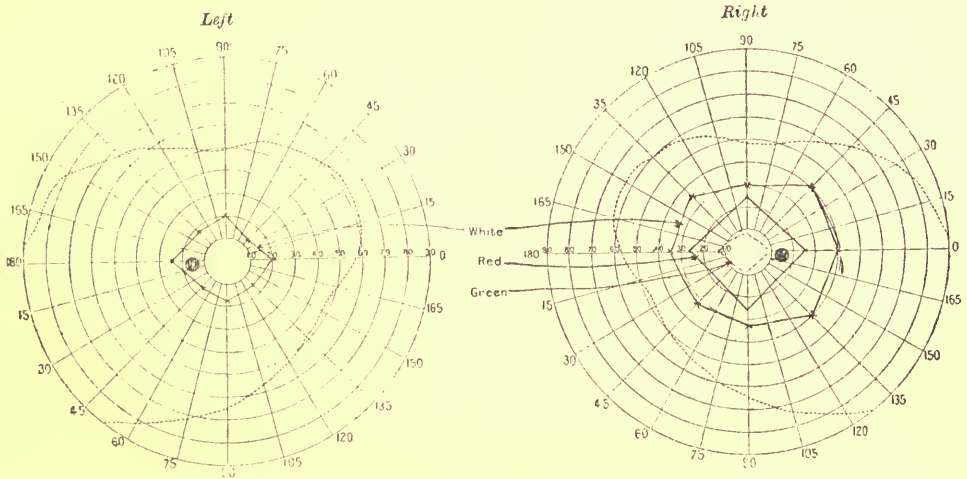

Fig. 1.—Visual Fields of Case No. 55.
Examination, February 26th, 1916.
In Right eye vision defective since 1901 (S. African War).
In Left eye vision defective since May, 1915.

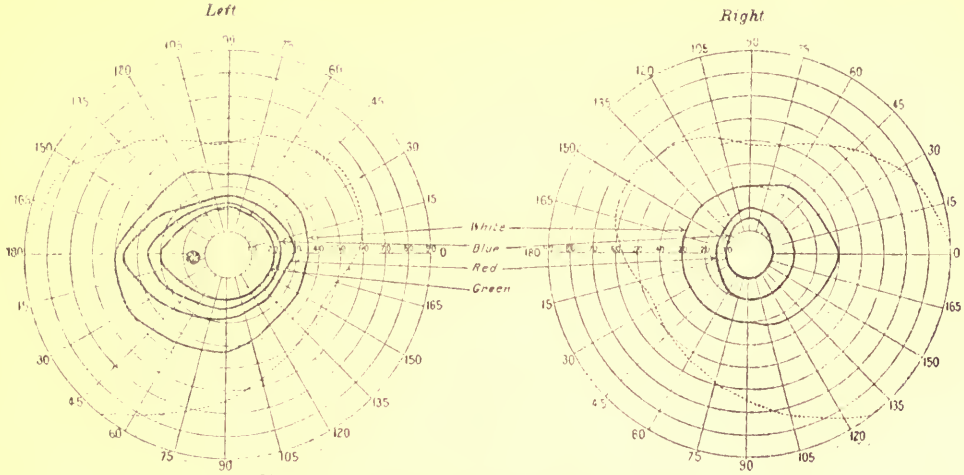

Fig. 2.—Visual Fields of Same Patient.
Examination, March 29th, 1916.
Left eye under treatment since March 9th=3 weeks.
This field is expanding in all directions.
No essential change in the right field of vision—the untreated eye.

although hearing, smell, and taste were normal. The patient was right-handed. He was in an extremely "jumpy" condition when seen three months after the following experience :—

"We were three in a trench, which was under shell fire. Two were standing ; I was huddled up. Observer sang out that a shell was coming. I was on the ground and put my head between my ankles. The next thing I knew was that I heard them saying: 'It's no use digging any more,' and then a second shell burst. I came to on the boat, and found my left arm in a splint. The arm had not been fractured and the splint was taken off next day, but I had been buried under seven feet of earth. I was unconscious about half an hour."

Although there was no history of an earlier breakdown, there were plenty of traces of a psychopathic disposition ; the patient recovered rapidly, but he was not suitable for the front line.

Hemeralopia is not infrequent in a mild form, objects being less distinctly seen at night than formerly ; total blindness at night also occurred. In an albino[7] with absence of pigment in the eyes there was also intense photophobia; according to the patient's statement there had been no trouble with the eyes, no hemeralopia until the Salonica campaign. The hemeralopia improved, but it did not completely recover whilst under treatment (10 days). Hysterical strabismus has been also observed. Westphal[8] records the following extensive hysterical eye symptoms. After a slight injury to the back of the head there occurred ophthalmoplegia externa, which alternated with spastic contracture of the rectus internus, miosis

7 Not included in the Appendix. He came under my care when having temporary charge of the eye department.

8. Quoted in Zeitshrift f. d. gesammte Neurologie u. Psychiatrie, Bd. 12. Heft 4, 1916. p. 340.

and increased reaction to light. Further, blepharoclonus, intense contraction of the visual field, central scotoma for all colours, convergent spasm in any light, analgesia, aguisia, with convulsive attacks when excited, pronounced hysterical state and inhibition of thought. The symptoms were dependent on and influenced by the examination. [Which side of the head was injured and which eye was affected are not stated in the abstract.]

DEAFNESS.

Deafness is in many cases associated with other symptoms. I have already alluded to its occurrence with mutism and hemianæsthetic states.

No. 49 was blown into the air by a shell, but not rendered unconscious. He immediately became deaf in both ears. When seen a fortnight later he was completely deaf. There had been no previous history of ear trouble, and nothing on examination beyond a little cerumen in both ears (removed without any improvement of the deafness). The sense of smell was absent, but sight and taste were normal. Analgesia of the head and upper part of the neck to the collar line. Speech, writing and reading unimpaired. Under suggestion in the waking state the patient a few days later regained his hearing as suddenly as he had lost it.

Commoner than partial or total deafness is increased sensitiveness to sound; the patient starts at the slightest sound, he seems to be afraid, as it is said, of his own voice.

SMELL.

Smell may be absent altogether, as in the deaf man just quoted, or, more frequently, it is absent on one side and that usually the left side. As in most of the hysterical disturbances of the senses this is associated

with other stigmata, *e.g.*, anæsthesia of the corresponding side of the body. Hypersensitiveness to smell is also found; some horrible smell may persist in the memory, as in Mann's case[9] of trance condition, which followed the digging and filling up of pits for masses of corpses. The patient could hardly react to external stimuli, only saying from time to time, "What a smell—leave me alone."

TASTE.

Taste may be entirely lost or absent on one, pre-eminently the left, side. A constant "bad" taste in the mouth is a common complaint. An Australian had constant pain in the back after a fall from his horse in camp. This got better and he had then bad abdominal discomfort. After a time the symptoms disappeared, to return whilst in the trenches; they finally left him, but he had a "nasty taste in the mouth." It was so bad and his appetite and his general health were so much affected that he was sent to hospital. The teeth were good, nor could anything be discovered amiss on physical examination. The choicest foods having failed to remove the "nasty taste," recourse was had to suggestion under hypnotism. The success in this case must not be regarded as a possible addition to the normal commissariat arrangements.

TICS.

My experience agrees with that of others, *e.g.*, W. Schmidt[1] that tics are more especially found in the muscles of the face, neck and shoulders.

No. 60 had a slight superficial wound of the right knee, followed the next day by pains in the back and

9. Mann. Ueber Granatexplosiven Störungen. Arch. f. Psychol., 56. Heft. 1.

1 Schmidt. Die psychischen und nervösen Folgestände nach Granatexplosionen. etc. Zeitsch. f. d. Ges. Neurologie und Psych., 29. H. 5, 1915.

shoulders; he was sent into hospital for "nervous debility." In addition to the symptoms of anxiety-hysteria, to be described later, he had a twitch of the lower jaw. This was rather slowly depressed and the mouth opened with a sigh as if about to yawn or take a deep breath.

Spasms occurred at irregular intervals, but sometimes two or three times in a minute and then left off for 10 minutes or longer. Among numerous symptoms was diminished visual acuity, $\frac{6}{60}$ R. and L. An officer to whom this man was most attached, and whom he had known in England before the war (both came from the same place), was killed alongside him in the trenches; the patient had seen his officer gasping for breath in the death agony. To use his own words, he "had never seen such sights before." This neuromimesis was, it need scarcely be said, quite unconscious.

No. 59. *Blinking of the eyes* followed an attack of conjunctivitis in a lad of 19. On December 10th, Captain M. M. Townshend,[2] R.A.M.C., reported his R.V = $\frac{6}{24}$ and L = $\frac{6}{36}$ and the defective sight as probably due to the constant blinking, since he was quite unable to fix on anything. The fundus was normal and there was less than a + 2 error of refraction. There being no improvement, he was submitted to psychotherapeutic treatment on January 12th; the blinking stopped at once; on January 14th Captain Townshend examined him again and found V. R. and L. = 6/6.

No. 77 had frequent myoclonic spasms of the left face, wrist and shoulder girdle, with a great tendency to elevate the left shoulder. It was as if he were continually shrugging one shoulder. This patient had contraction of the field of vision, absence of smell and taste, and diminished hearing on the left side, together

2 Specialist in Opthalmology at Hospital, Malta.

with complete left hemianæsthesia and analgesia. The case is described in more detail on page ; we shall deal with other instances of somatic disturbances in the next chapter in the discussion of their psychological mechanisms. It would be wearisome to repeat the clinical pictures of the functional war-palsies which, as we have sufficiently illustrated, may affect any part of the motor or sensory system.

GANSER TWILIGHT STATE.

Hysterial fits, fugues, autopsychic amnesia and somnambulism will be discussed more fully in relation to the psychology of these conditions ; here a brief clinical account of one such case will be given.

No. 76 had a shrapnel wound in the right calf; the wound was not serious and was almost healed when he came under observation some weeks later. Shortly after his admission to hospital for the wound his mind became a complete blank. He had a strange dazed expression; when spoken to he stared at the speaker as if trying to gather some impression, and would then shake his head, making some irrelevant response. It was difficult to make a satisfactory physical examination, but one could be satisfied that there was less response to pain on the left side of the body than on the right (probably complete left hemianalgesia). The reflexes were normal and there were no motor disturbances.

Speech was normal, and as far as could be ascertained so were hearing and sight ; taste and smell were not affected.

Memory.—Personal.—The patient did not know his name, address, whence he had come, that he had been engaged in a war, where he had been fighting; he had no recollection of going to school.

Recognition.—He could recognize the use of objects ; if, for example, told to make his bed or put

on his boots, he would execute the order. He knew what to do with matches, cigarettes, and so on—there was no apraxia.

Response to questions of the simplest kind could not be obtained.

Have you got a pair of boots? I don't know.

Do you want cigarettes? I don't know. (He would take them when offered.)

How many fingers have you? Four.

Where is the wound? Don't know.

There were no hallucinations, and the patient was able to find his way about the wards and grounds; he would even keep appointments correctly with me at my room, so that in a practical sense he was not disorientated as to time and space. Ganser[3] first called attention to this peculiarity of response in certain twilight states associated with hysterical stigmata, and the condition has been since frequently observed. I am not acquainted with any case where, as here, there was no neuropathic basis, and, to a very large extent, practical sense was preserved.

The patient made a complete recovery under hypnotic suggestion.

A group of clinical interest is provided by the

AFFECTIONS OF THE VEGETATIVE NERVOUS SYSTEM.

These may be simple or multiple; of the former, hysterical vomiting, enuresis, diarrhœa, nervous indigestion, and the soldier's heart demand consideration here.

HYSTERICAL VOMITING.

No. 65, 28 years of age, began vomiting after food in August, 1915, whilst at M.; this took place two

3 Ganser. Ueber einen eigenartigen hysterischen Dämmerzustand. Archiv. f. Psychiatrie, 1898. Bd. 30, p. 633.

hours after food; on the Peninsula he got worse. He continued doing ordinary duty till November, when he was sent to Malta. Vomiting had now become continuous, nothing, not even water, could be kept down. He had been kept in bed for some weeks and various diets had been tried, including neglect (purposeful) without any relief. Examination on February 3rd, 1916, showed a well-nourished body without any signs of emaciation or physical condition to account for the sickness. The anamnesis disclosed that the vomiting was a neuro-mimesis from identification with the patient's favourite brother, who suffered from frequent "bilious attacks" attended by vomiting, in many of which attacks the patient had acted as nurse to his brother. This knowledge was used in suggestion under hypnosis. The vomiting ceased on the third day of treatment, the patient being put on ordinary diet.

ENURESIS.

Enuresis yielded to psychotherapeutic treatment in a case (No. 63) where the condition had arisen after joining the army; in another case (No. 67), in a patient aged 20, where the enuresis had existed as long as he could remember, no improvement resulted.

DIARRHŒA AND INDIGESTION.

Diarrhœa and indigestion are most frequently connected with other vaso-motor troubles; sometimes with vomiting (No. 64).

THE SOLDIER'S HEART.

As *Punch* says, cardiology "must be far and away the most popular subject at the present time," and perhaps many of my readers may even agree with

Punch, who had "an idea that the finest experts are not attached to the Medical profession."

The particular variety of the soldier's heart, where perhaps *Punch's* non-medical expert may be more successful in her treatment than the professional adviser, will be familiar to all military doctors. The following is the picture given by Sir James MacKenzie [4]:—

"When we see the soldiers in this country invalided because of heart trouble, we find a good deal of variation in their appearance and symptoms. The face is often lined and drawn; many are spare and thin with a great vaso-motor instability, as shown by the manner in which the peripheral circulation varies—the hands and fingers at times going pale and cold; at other times the fingers are thick and red, and the nose likewise becomes red and even blue with slight exposure to cold. If they have been treated for some months by rest and feeding, some become pale, fat and scant of breath.

"The chief complaint is an absence of the feeling of being well—they often feel out of sorts; 'rotten' is a term frequently employed. A sense of fatigue or exhaustion easily induced is common to all. Breathlessness on moderate exertion is frequent; pain over the region of the heart less frequent. The physical signs are variable. The heart's rate is often not increased, in some it is persistently increased, as frequent as 120 per minute. More frequently at rest the rate may be quite moderate, but exertion, sometimes slight, may produce an undue rapidity, and it is in consequence of this excitability that the term 'irritable heart' has been used. Murmurs, systolic in time and heard in different regions, are frequent,

4 Proceedings of Royal Society of Medicine—Vol. IV., No. 4. July 1916. Therapeutical and Pharmacological Section, p. 28, *et seq.*

while an increase in size, usually slight, is not uncommon. In a few cases there is a slight œdema of the legs. The mental condition is somewhat varied. Periods of depression are not infrequent, and the patients are often very irritable. They accept the view that they have something wrong with their hearts and readily yield to all restrictions, and are often content to lie in bed and brood over their woes."

MacKenzie says that the condition is not really cardiac in origin, but is "the outcome of an injury to other systems as well as the heart, such as the central nervous system." He recommended that these patients should be treated by fresh air and judicious exercise in the open air; fishing, riding, golf, etc., for those who could afford it, bowls, quoits, or skittles and so on for the less fortunate. "As soon as signs of improvement are shown, the soldier should begin drilling." He recognised that it is the mental condition of the patient that chiefly requires attention—to take the patient "out of himself;" that "the sense of exhaustion is the predominant symptom and that it is probably vaso-motor in origin, due to the irritation of the cerebral nervous system."

Freud[5] has described exactly this condition occurring among civilians; it may be the chief and only symptom of anxiety-neurosis and anxiety-hysteria; disturbances of the heart's action, palpitation and brief arrhythmia, with longer attacks of tachycardia up to severe conditions of cardiac weakness, the differentiation of which from organic affections of the heart is not always easy, attended by depression, anxiety, and other mental conditions. A special and

5 Freud. "Ueber die Berechtigung von der Neurasthenie einen bestimmten Symptomencomplex als Angstneurose abzutrennen," "Neurologische Zentralblatt," 1895, No. 2.

See also "Anxiety-Neurosis" in Selected Papers on Hysteria, by S. Freud, translated by Dr. A. A. Brill, New York: The Journal of Nervous and Mental Disease Publishing Co., 1912.

unnecessary name (phrenocardia) was coined by Herz [6] in 1909 for this same condition.

It is important to remember, as Leyton [7] has pointed out, that the soldier's heart may arise from disease of the heart or disease of the vaso-motor system. "In some cases the two sounds of the heart were of equal intensity, and these I believe were suffering from myocardial alteration, probably of toxic origin. In other cases, however, there was no alteration in the ratio of intensity, and in these I am under the impression that the disease was of the vaso-motor system. It would be of considerable interest to determine how far the observations of this type could be corroborated when applied to very large numbers, and whether, as predicted, nervous shocks such as those produced by high explosives led to disturbance of the vaso-motor system, which may last for a considerable period, whilst toxins of bacterial and other origin, such as gases, cause disease of the myocardium." For this disease, of course, psychotherapy would not be the treatment. We will describe briefly some cases of "soldier's heart" *i.e.*, of functional heart attacks, corresponding to MacKenzie's picture, which were treated and cured by psychotherapy.

No. 68. An Australian, aged 23, was blown up by a mine in a trench, knocked some yards, and remained unconscious for several hours. This was not his first "shell-shock." Has been sleepless and unnerved ever since; much pain over the heart. This gets worse on the slightest exertion, his heart then beats violently. There is a fine tremor of the hands (eight per second) and some tremor of the legs when he walks. A systolic murmur heard at the apex. Physical examination otherwise negative.

6 M. Herz. "Die sexuelle psychogene Herzneurose (Phrenokardie)." Vienna: Braumüller, 1909.

7 Proceedings of Royal Soc. of Medicine. *Loc. cit.* p. 49-50.

The patient is a teacher in a town in Australia where he was born and where he has lived all his life. He regards fighting as an ignoble profession. He enlisted in a burst of enthusiasm, but has regretted it ever since.

So much for the conscious attitude. A different attitude was shown in the unconscious. Here we had to do with an extremely aggressive and primitively savage type. He dreamed of attacks upon the Turks, he is leading on his men. He had a recurring phantasy of plunging a dagger into the navel of an enemy and turning him round as upon a spit. We had no means of giving the patient the excellent treatment advocated by MacKenzie but by the help of suggestion, in the waking state, his condition improved. After 20 days he was sent to a convalescent camp and rejoined his unit six weeks later.

No. 70, a soldier aged 31, who had been in the Gallipoli campaign, was sent into hospital for "rheumatic" pains in the legs. He suffered from sleeplessness, breathlessness and such intense exhaustion that "lifting one leg in the bed quite does me up." The thyroid was diffusely enlarged; no ocular signs of Grave's disease. Fine tremors of the legs. No other signs of disease of the cerebral nervous system.

The blood pressure was high, 160/90; tachycardia, irregular pulse, no displacement of the heart, and no murmurs.

Besides the vaso-motor signs mentioned, there were sweating of the palms, pollakuria, occasional diarrhœa.

Under hypnotic suggestion the patient was in eight days able to get about and his symptoms, the exhaustion and sleeplessness, disappeared. The tremors and tachycardia were slower in removal, but eventually ceased. It was my opinion, as well as that of other observers, that the thyroid had diminished

considerably, but unfortunately no measurement was taken on his earlier examination.

We shall return, however, to the consideration of enlargement of the thyroid when discussing the other variety of hysteria.

CHAPTER III

PSYCHOLOGICAL MECHANISMS IN CONVERSION-HYSTERIA

AUTO-MIMICRY

THAT the hysterical manifestation is frequently a mimicry of symptoms seen in others is, of course, well known. It is also to-day understood that such mimicry is not conscious. It is, I believe, less well recognised that the hysteric may mimic the symptoms of an illness from which he has himself suffered. Ziehen seems to have used the term auto-mimicry, I presume in the sense in which it is here employed, although I have not been able to trace the passage. Gatti[1] gives a case of this kind in a girl who in childhood suffered from epileptic fits, and at the age of 18 had hysterical attacks which mimicked the earlier epilepsy.

The following cases show this auto-mimicry somewhat clearly:—

No. 20, aged 21, of four years' service, was admitted on March 14th, 1916, to hospital, Malta, with a diagnosis of traumatic epilepsy.

The following history is as given by himself. In the middle of November, at Gallipoli, he was wounded in the left side of the head and at the back of the head

1 Lodovico Gatti. "Il fenomeno di auto-imitazione nelle associazioni istero-organiche": Rivista italiano di Neuropatologia. 1913, Vol. VI., p. 159.

by a piece of shrapnel. He was unconscious for five days and woke up as he was being taken ashore at Alexandria. On awaking he had to satisfy himself by looking and touching that he had not lost his right arm and leg. He had no feeling in those limbs and was unable to move either the arm or leg for three weeks; the leg gradually got better and then the arm began to improve. He states that he stammered for some days. Two operations were done upon him (nature unknown, probably not of surgical severity). He remained in hospital till the end of January, the first weeks in bed. He suffered a good deal from headache (frontal). On leaving the hospital he says he was able to walk, but the right leg was weak; he had no power or feeling in the right arm. From Alexandria he was sent to camp in Mudros. Here he had three fits.

1st. About first week in February, 1915, when, after a little dispute, his "head went dizzy" and he lost himself. The orderly told him he was violent; he does not know how long the fit lasted; it was followed by a headache.

2nd. About February 20th, he was in a billet with some others when again, after a little dispute, his head was dizzy, he had a buzzing in both ears, and on awaking recalls being slapped by a doctor.

3rd. At the beginning of March, in the same place, he was repairing a telephone and was being "hustled" by the driver of a motor-lorry outside; again felt dizzy and buzzing in the ears, and remembers doctor's presence on his awaking.

In none of the fits was there any incontinence of urine, nor did he hurt himself nor was the tongue sore.

Only after the first fit did he speak of a headache following the attack.

Examination: Patient is a right-handed man of powerful physique; speech and articulation normal.

There is a small circular scar, ¼ in,, over the left upper temporal region, ½ in, behind Rolandic line and 2½ in. vertically above tip of left mastoid.

Pupils and cranial nerves are normal,

The fundi are normal, as are the visual fields.

There is anæsthesia and analgesia of the right side of face to middle line, of the whole of the right fore-quarter and of the right lower limb from the toes to a hand's breadth above patella,

Though patient does not feel the pricks of a pin (the pin can be driven and left in the skin), when told to place his left hand (the eyes being shut) on spots indicated by the examiner's hand, he is able to locate with his hand the area so touched. Grasp of right hand is feeble; the leg appears of normal strength.

Joint sense deficient in fingers, wrist, elbow, shoulder and toes of right limbs.

Astereognosis: fails to recognise hair-brush, knife or key in hand or foot.

Gait normal.

The right hand cannot be used, *e.g.*, cannot hold a spoon, fork, or cut with a knife.

Reflexes: supinator and ankle jerks are present. No ankle clonus. The plantar reflexes are present. Abdominal reflexes are present and equal.

The muscles of fingers and wrist react normally to faradism.

X-ray examination showed a piece of metal in the diplœ immediately beneath the scar.

A diagnosis of hysterical (functional) anæsthesia and paresis of the right hand was made from the distribution of the analgesia and the electrical reaction. The fits were concluded to be hysterical.

But that the patient had had a temporary organic hemiplegia immediately following the injury is clear from (1) history, especially his looking and touching to see if the limbs were present. In my experience

this is unusual in purely hysterical conditions, in accordance with what would be expected from the psycho-pathology of this condition. (2) The site of the injury as shown by the presence of metal. (3) The disorder of speech (stammering) immediately after the injury.

On March 16th suggestion under hypnotism was carried out, when the analgesia disappeared from face, right shoulder, and leg.

March 18th, second treatment by suggestion under hypnotism, analgesia confined to forearm.

March 23rd, complete disappearance of analgesia and recovery of use of hand.

The patient remained perfectly well from April 9th, when I last examined him.

The diagnosis was confirmed by Col. Purves Stewart, A.M.S., consulting physician, and by Col. Thorburn, A.M.S., consulting surgeon to the Malta command, who also agreed with me that surgical interference was unnecessary.

The first hemiplegia was presumably due to a hæmorrhage, following the shrapnel wound; this rapidly cleared up and was succeeded (apparently without a break) by the functional hemianæsthesia and paresis.

Case No. 31. Aged 24. $1\frac{5}{12}$ years service; was wounded on January 7th, on the back of the right wrist and right side of face. Both wounds were superficial and healed in about ten days. The day following the injury the left hand began to hang down; he first noticed it hanging on going down to the boat for embarkation to Malta.

Patient is a right-handed man.

Examination on January 27th presented a typical drop-wrist of the left hand. There was analgesia (to pin pricks) to one inch above the wrist. Supinator reflex present. The wrist cannot be extended and

no movements of thumb and fingers can be performed. Movements of elbow and forearm are normal. All the muscles of hand react to faradism. There is a small scar on dorsum of right hand.

The patient states that the right hand dropped a little immediately after the injury, but only for a short while, and it recovered at once.

January 28th. Treatment by suggestion under hypnosis; readily hypnotised and feeble movements of thumbs and fingers obtained.

An attack of paratyphoid interrupted further treatment till March 16th; in the meantime the movements of fingers and thumb became slightly more extensive, but the wrist could not be extended. Abduction and adduction of fingers were quite impossible.

March 16th. Treatment resumed, and on March 28th a note says he has now complete movements of wrist and fingers, there is no analgesia; the grasp is still rather feeble. Massage was now used and the full power of hand soon restored.

That the functional disorder occurred on the left side (and not on the right) is in accordance with the rule that functional disorders are preponderantly on the left side in right-handed persons.

Here we again see that the hysterical lesion mimics the original physical trauma.

No. 22, aged 23, wounded on December 27th, in Gallipoli, by a shrapnel bullet at the left elbow; the wound of entry being 1¾ in. above and 1½ in. in front of external condyle; the exit wound was ¾ in. above and 1¼ in. in front of internal condyle, Bullet track crossed beneath tendon of biceps emerging behind the brachial artery. There was no injury to the bone.

He complained of pain from palm of hand to tips of fingers.

The elbow was flexed to an acute angle and could

be only slightly extended by passive movement which caused great pain, the biceps tendon becoming very tense. He could not flex, without great difficulty, any of the interphalangeal joints; the terminal phalanx of thumb and index finger could not be flexed at all. Supination was fair.

Analgesia and anæsthesia extended from finger-tips to one inch above wrist, on both aspects; vibration sense was lost in fingers but, not in radius or ulna.

All muscles of forearm and hand reacted normally to faradism.

The patient is a right-handed man. He says that the arm jumped up directly it was hit; he at first thought he had lost the arm; from the time it went up he had been unable to bend it.

He was first hypnotised on January 27th, when under suggestion he was able, although with signs of pain and resistance, to move the elbow and the fingers more freely. The analgesia receded and was present only over thumb and index fingers and their corresponding metacarpal bones. This patient was under treatment till February 15th, by which time the analgesia had disappeared, the elbow, wrist and finger movements were perfectly restored. He still had difficulty in flexing the distal phalanx of thumb, but he was able to bend it with effort.

From the position of the wound, and the immediate flexion of the elbow and fingers, it seems clear that there must have been some passing injury to the biceps tendon and the median nerve.

This passed off, but the "memory" of the pain persisted, leading to a mimicry of the original physical injury.

The relationship of shell-shock—of the physical injury—to other functional affections, such as mutism, has a similar explanation. The explosion produces

a commotio cerebri causing loss of consciousness ; this physical condition lasts a certain time. On recovery there is a hysterical mimicry of this condition which is sometimes complete, when there is entire loss of consciousness with amnesia for the period ; in other cases it is less complete—or the one state may gradually pass into the other—and the patient remains partly shut off from the external world, dumb, deaf and dumb, paralysed and so on. These patients are mimes, they are acting the part they played when they were hit.

Sometimes (No. 36), this proceeds from a wish to remain unconscious (to be dead); "he would rather die than have to go through it all again," as this patient put it to me. The motive, however, varies and we shall deal later with some of these motives.

2.—HETERO-MIMICRY.

An instance of the more common form of neuro-mimesis has been given on page , in the corporal with the tic of the lower jaw, a mimicry of the death spasm of an officer to whom he was devoted. Another example was supplied by No. 65, briefly mentioned on page 41, whose history is worth a little further study.

a. Identification with a brother.—No. 65, a private, 28 years of age, suffered from hysterical vomiting. The history showed identity with a brother, who suffered from some form of gastric trouble accompanied by vomiting. This favourite brother had often been seen by the patient in these attacks during which he at times sat up all night with him. The patient had been brought up in an orphanage till, at the age of 17, he was discovered by this much older and married brother, who then took the lad to live with him and "did everything for me." What this "everything" meant here may be gathered from the

patient's account that up till 17 he had never been allowed out by himself, he had never been into a shop to buy anything. The authorities of the orphanage took entire control of the children—in this case until the age of 17. Thus, when claimed by the brother, the lad's entire education for life had to begin. He was really a child emotionally, still very backward—nor can I say that he had, in compensation, been intellectually stimulated. His brother had found a trade for him, and he lived financially free, but in other ways most dependent upon the brother until he enlisted. He remained well in England, and on board ship, but very soon after arriving at Mudros, preparatory to the Peninsula campaign, the vomiting began.

This slight sketch of his life will show, I think, that early environment was adverse to the man's acquiring mental self-dependence ; placed under the new conditions of life it is not surprising that he developed this "sympathetic" vomiting, betraying his need for the brother, the helper and consoler.

The unconscious imitation of another's passions, dress, language, tricks, illnesses, is an endeavour to identify oneself with the object. Such identification may be, of course, partial, the subject identifying himself with the object in some particular quality, often symbolised by a particular piece of mimicry ; in other cases the imitation is complete, one "plays the sedulous ape" to some reverenced or adored personality. In this soldier, the identification with the brother's illness had a further significance which was brought out in the course of his examination. If he were ill like his brother, that is, if he were the brother, he would be in England, not fighting in Gallipoli. He therefore becomes the brother.

b. Identification with a horse.—An interesting instance of this variety of hetero-mimesis, which

plays so large a part in the totems and taboos of primitive man, was furnished by a patient in whom such identification managed consciously to dispose of a very natural fear—fear which Charcot called the *agent provocateur* of hysteria. The case is discussed on page 79.

A development of the condition shown in heteromimicry is the identification of a third person with the loved object. A hysteric, for instance, still emotionally under the influence of his love towards his father, will find in some other more or less suitable (dramatically suitable we might call it) person all the qualities bestowed upon his father; he identifies the third person with the father and takes up the filial position towards him. The bystander may find very little evidence of the similarity between the father and the other person, but with a certain emotional attitude, with the need to possess a father, phantasy will bridge all the difficulties. Oh, that he were my father! Oh, that my father were alive! soon becomes—He is my father! My father is alive and can help me! This mental process, and the importance of its recognition, has been dealt with by Freud under the name of

TRANSFERENCE,

a good instance of which is furnished by the blinking boy, No. 59, p. 39.

He was cured, by suggestion, of the blinking of both eyes and amblyopia, after the relation of his history. His father was an immensely powerful man who used "to lift horses and carts with his teeth." Every night his father would come to the bedside and talk with him, bringing him presents. When the patient was aged 4, his father was brought home one Christmas morning by the police; he had been found in a field unconscious, with an injury to the head; he died a

few minutes after being brought home. There was strong suspicion of foul play, but nothing was discovered. His mother used to talk to the boy very much about his father, dilating on his great strength, his goodness and tragic end. This lad had been four months in the Peninsula; the vision of his father was constantly before him, especially his being brought in by the police, and the death scene. He tried to think of something else and tried to close his eyes to avoid the sight. The blinking is thus seen to be here symbolical of a desire to shut out a visual memory picture; it is common enough to close the eyes when any gruesome picture looms up. The revival of the memory of the father, the strong man, had many determinants. It took him back to childhood, with a wish that the strong father might be there by his side; then the enemy would be overcome and he would have no fear. Again, the death scene: he was strong and well himself, but like his father he might be killed suddenly and by some unknown hand. His mother would not know any more about the details of his death wound than she did about his father's.

This history, with a great deal more about his home and his early life—he was a very good boy and took all his earnings to his mother, who had married again since his enlistment—the lad related to me amid great emotional distress. He burst into a flood of weeping as he told me the story—and at the end of an examination and talk, which lasted some two hours, he was cured. The blinking ceased forthwith; we discovered subsequently that he had identified me with his father, and transferred the feelings he had experienced towards his father to me. His father was not dead then, his father was alive and must look after him. Doubtless, the air habitual to a middle-aged paterfamilias, my sympathetic interest in the

boy, and perhaps a something in my personal appearance, were sufficient to set the boy's mind weaving its phantasies around me. I may add that during the next few weeks, when he remained in hospital, his filial attitude to me (in the best sense) persisted, and he would seek my opinion and prattle with me about all sorts of matters.

SYMBOLIC CONVERSION.

This patient, by his blinking, gave expression to his unconscious ideas in the oldest form of language—gesture. It is to Freud that we owe our understanding of the meaning of these symbolic actions. It is in the unconscious that we find the springs of action and of thought—a region (this and similar terms are used figuratively) of the mind whose rich and varied emotional nature we are beginning to appreciate—a region less under the control of the conscious intellect than had been heretofore supposed. Emotions inhibited from transference into action do not pass into nothingness, but persist in the unconscious, often influencing the whole life of the individual in some distorted and irregular way, perhaps biding the time till opportunity occurs for their manifestation.

No. 24. The Irish soldier with the 15 bayonet wounds (see page 25) had a functional claw-hand (*main en griffe*).

In recounting the story, which he did with much vigour, I noticed his repeated and emphatic statement: "In such fighting you must clutch your rifle very firmly and never let it go, guarding yourself all the time." The explanation of his contracture becomes obvious. Grasping the rifle was the very attitude his hand still assumed; in the unconscious he was still clutching the rifle; he was still fighting the good fight, and this desire was symbolised by the grasping hand. I was able to confirm this view under

hypnosis, for on suggesting to him that the fight was over and he could let go the rifle, his hand immediately relaxed. We then got a little deeper into the meaning of this persistence of the unconscious desire for a continuance of the fighting by the patient's remark that when he takes up a thing he likes to carry it through to the best possible extent. He especially prided himself on his bayonet work.

The following is one of the many dreams he related to me:—

"*I saw a person walking along a muddy bank. He had on a long gown; he was a priest. Some Turks caught hold of him, only they were dressed in khaki; they were going to torture him when I arrived with others.*"

This and other dreams suggest there was a still deeper motivation for the hysterical symptoms than I have given, but it was not possible to penetrate into this as the symptoms promptly disappeared under hypnotic suggestion.

THE MEANING OF HEMIANALGESIA.

Some authorities, following Babinski, consider that hysterical anæsthesia is produced by the suggestion of the examining physician; the above case seems to be at first one in point. At the beginning of the examination there was no analgesia at the right wrist, but on re-examining the wrist analgesia was present.

The fundamental difference between an organic and a hysterical anæsthesia is this: In organic anæsthesia there is interference with sensory conduction on the physical side; in hysterical anæsthesia there is no such interference. Sensation reaches the unconscious but is there inhibited from reaching consciousness. In this case there was nothing amiss with the skin, the sensory nerves, the brain; in fact, the uncon-

scious did feel the light touches and the pin pricks but refused to make the conscious mind aware of them.

What is the meaning of this refusal? The anamnesis showed that during the fight he felt no pain, he did not indeed know he had been wounded until, on being taken away much exhausted after his exertions, his attention was called to the blood coming from him. This young Irishman was a highly strung young man, sensitive to pain as he admitted. Had his conscious self felt pain on the battlefield he would either have had to retire from the struggle or let go his rifle and be killed. The whole of the exposed area (the right side of the body) was in this case not admitted into the field of consciousness. The motive was the same as Nelson's conscious motive in putting up his telescope to the blind eye at the Battle of the Sound. Nelson wanted to go on fighting. So did this soldier; he was not to be put off by feeling the pain from ever so many bayonet wounds. He would not allow himself to feel pain.

The analgesia disappeared a few days later. Its revival under the pin pricks of Col. Stewart is readily understandable. The unconscious is, as will be abundantly shown, archaic and primitive; it is not finely discriminating. Here it did not distinguish the harmless pin pricks of Col. Purves Stewart from the harmful bayonet thrusts of the Turks. It took no notice of the first prick or two, but as the jabs continued up the arm the earlier memory was revived and the unconscious was on guard: The Turks are at it again! Returning to a similar experience the unconscious developed the same mechanism of defence, whilst the perception did not pass from the unconscious into the conscious. Counter suggestion soon restored the normal condition.

In another case, one of vomiting (No. 64), this symptom expressed the patient's disgust at the scenes

he had witnessed in war; "loathsome" was the word he constantly used to me in describing these scenes. The expression "sick with horror" is more than a metaphor. In my patient it expressed physically his repugnance to war.

ANALGESIA AS AN ANÆSTHETIC.

Another motive for the anæsthesia—where ignorance is bliss—is shown in No. 1 (see p. 22), where the anæsthesia prevented any direction of the patient's attention to the affected side; a defence mechanism which prevented worrying. The patient had always, in his own words, been as strong as anything, and never ailed a day—barring the accident. Under hypnosis the suggestion that he could feel normally everywhere was at once responded to. There was no motive in maintaining the anæsthesia now that the patient had discovered his own trouble. A little later he began to have sleepless nights, and he came to me complaining of a change in his character—irritation without adequate provocation. This was the result of his discovery, for having, through accidental causes, to be kept in the hospital rather longer than was intended, he assumed that he would be discharged unfit. He was reassured and remained quite well during the rest of his stay in hospital (10 days), but the trouble is not unlikely to recur in other forms.

WHY FUNCTIONAL ANÆSTHESIAS ARE LEFT-SIDED.

The left is the side of election for hysterical manifestations,[2] in war as in peace. It may be said generally that if the hysterical symptom occurs on the right side there is some particular cause—the patient is left-handed or the symptom is grafted on to some earlier or still existing organic defect, or the

2 Purves Stewart. "The Diagnosis of Nervous Diseases," 4th Edition. p. 392. London: Edwin Arnold.

right side is physiologically adapted to the psychological motive.

In No. 24 the patient is left-handed and the right half of the body was advanced in the bayonet fighting; it was on this side that he received fourteen out of his fifteen bayonet wounds. In such cases as Nos. 2, 19, 20, 21, 23, the selection of the left side *seems* quite arbitrary.

Oppenheim[3] attributes the greater preponderance of left-sided over right-sided symptoms to the relatively low vitality of the right hemisphere of the brain, a statement without any physiological value and of course having no psychological meaning.

Lewandowsky[4] suggests that the left-sided selection has a psychic factor—the much greater inconvenience of the paralysis of the right side. It is, however, to Stekel's[5] analysis of dreams, of hysterical fits and giddiness with the tendency to fall on the left side, that we must look for the full meaning. He pointed out that right and left are used not only of direction, but are terms denoting mental and moral judgments. We say, "He's all right"—"To get out of bed with the left foot foremost." In the posters of "The Girl who took the Wrong Turning," the artist depicted the beautiful but naughty heroine turning to the left at the cross-roads. The left-sided phenomenon is a symbolical expression meaning that things are wrong with one. "Up" and "down" are used similarly by the unconscious—we speak of a fallen woman, an elevating book, down in the dumps. Every observer, of course, pays attention to the general bearing of his patient, noting whether he walks with an erect posture, head and eyes

3 Berl. klin. Wochenschrift. November 3rd, 1915.

4 Zeitschrift für die gesamte Neurologie und Psychiatrie, 1916. Vol. XII., No. 4, p. 427.

5 Stekel, W. Jahrbuch f. psychoanalytische u. psychopath. Forschungen, Vol. I., p. 467.

uplifted, or slouches along with bent back and downcast eyes.

SYMBOLIC GESTURE.

The translation of mental processes, verbal statements, moral judgments and so on, into their physical equivalents, plays a large part in the dream mechanism; it is worth studying some other instances of this process in hysterical symptoms.

No. 9. An Australian, aged 36, was admitted on January 24th, for stiffness and pain in the back and paraplegia. The sensory and motor disturbances in the legs improved considerably, but the back remained as stiff as a ramrod and more painful. The history he gave betrayed much feeling at what he considered inadequate treatment after a high-explosive shell had burst some yards from him on November 10th. He walked down to the dressing station and was given some pills and sent back to the trenches. The next day his back was painful, but he says he showed himself to the doctor, who again sent him back. In the trenches he was unable to move. On the fourth day he was sent into hospital and thence to Malta.

It must be understood that I am repeating this history not to criticise the medical officer, nor need we accept the patient's story as the account of what really took place. We accept it for its psychological value—it expresses what the patient felt on the subject, a feeling which gave rise to much emotional bitterness, even under hypnosis. The clue as to the meaning of this rigid back was obtained one day when he said in hypnosis : "*The doctor put my back up.*" There unfortunately the back remained when, having recovered the power of his legs, he was sent back to Australia, where one hopes it will come down under the mollifying influence of his wife and children.

Another instance of this symbolism occurred in

No. 43, the case of recurrent mutism referred to on p. 29.

This is the lad who was kicked on the *left jaw* by a horse on December 31st. (He also complained of inadequate treatment.) On January 1st, having been then admitted to hospital, he, whilst in bed, was taking part in a sing-song when he suddenly found he could not utter another sound. He remained dumb till the morning of the 4th, when on awaking he found he could whisper that he wanted his breakfast.

This is a pretty instance of one of Dr. Gee's aphorisms: "It is an interesting reflection that powerful emotion promotes eloquence and sometimes takes speech away." Whether the patient was an eloquent speaker I am not able to say, but I presume he was something of the sort; he was in the habit of preaching both before and since joining the army. On one occasion after joining the army he spoke for one and a half hours on the duties of a Christian soldier. He was always talking to his comrades, and nothing pleased him better than discussion or argument. Over and over again he had been told to shut up, hold his *jaw*. Now, after receiving the kick he went to his medical officer literally holding his jaw, and after the wound had been stitched was sent back to his tent. He felt inclined to *remonstrate* (*to jaw*), but thought it better to *hold his jaw*. Later in the afternoon the pain was so bad *in the jaw* that he was visited by the doctor and sent into hospital. The next evening, however, he found himself taking part in a sing-song—an inconsistency to which the unconscious promptly replied by "holding *his jaw*" figuratively.

THE MATERIALISATION OF WORDS.

It must be remembered that we are here dealing with what is archaic and crude in the unconscious,

with what links us, the heirs of all the ages, mentally with primitive man. In this lower culture there is no clear distinction between words and the objects they denote.

Sir J. G. Frazer[6] writes:—"Unable to discriminate clearly between words and things, the savage commonly fancies that the link between a name and the person or thing denominated by it, is not a mere arbitrary and ideal association, but a real and substantial bond which unites the two."

The utterance of the correct word, the power of the word, has a magical effect; the "Open Sesame" and "Rumpelstiltskin" of the fairy stories have been believed and carried out in our childhood's play. A Central Australian has but to get the magician doctor to pronounce a curse on his enemy: "May your heart be rent asunder; may your backbone be split" —and the enemy's backbone is split unless he get on his side a more powerful magician to ward off the words.

"When the Sulka of New Britain are near the territory of their enemies the Gaktei, they take care not to mention them by their proper name, believing that were they to do so, their foes would attack and slay them. Hence in those circumstances they speak of the Gaktei as *o lapsick*, that is, the 'rotten tree trunks,' and they imagine that by calling them that they make the limbs of their dreaded enemies ponderous and clumsy like logs. This example illustrates the extremely materialistic view which these savages take of the nature of words; they suppose that the mere utterance of an expression signifying clumsiness will homœopathically affect with clumsiness the limbs of their distant foemen."—Frazer, *ibid*, p. 331.

6 "The Golden Bough," Vol. III. "Taboo and the Perils of the Soul." 3rd Edition, p. 331.

A SPEECH-COMPLEX.[7]

The mutism can, in this patient (No. 43) be traced to early difficulty in his speech, for he began to speak late—not till after five—and he could not speak properly until he was ten years old.

I have pointed out elsewhere[8] that it is from the mother that the child gets his first encouragement to speak and that later on, in certain cases, resistance may arise against anything learned from the mother—against speaking altogether. There was in this case much opposition between him and his mother ; on account of this he was brought up to a large extent by other relations. After the birth of a brother, when he was returning to his own home, he told his mother that she was not his mother at all now that she had another child. Although he had never been dumb till the accident on December 31st, 1914, when annoyed at home or in the workshop he would take refuge in silence, sometimes not speaking to anyone for several hours. After the accident the subsequent attacks of mutism (four in two weeks) occurred after some excitement, such as winning at cards, attending church. There was a great deal in his history showing conflict between himself and his parents, a number of things which wounded the too sensitive disposition of the child. He took religion seriously (Wesleyan) at the age of 11, his parents being non-religious Church of England people. Without going into great detail the evidence may be summed up as showing strong conflict, conscious and unconscious, between son and mother in a person of sensitive predisposition.

Though he remained free for some time after his last attack, which was immediately stopped by

7 A complex is a system of ideas, dynamically active emotionally charged from an unconscious source.

8 Stammering as a Psycho-Neurosis. 17th International Congress of Medicine, 1913. Section on Psychiatry.

suggestion (without hypnotism), it is doubtful whether the same or other symptoms will not recur.

PSYCHOLOGICAL COMPENSATION.

This patient illustrates the mechanism which Jung terms psychological compensation,[9] and which Dr. Gee noted in the above quoted aphorism. This young man compensates for his verbosity by recurrent attacks of mutism; a phenomenon which, in a milder degree, had often been present. Thus, after an evening's heated talk (in his pre-soldier days), he had frequently lapsed into sudden and absolute silence, recalling Sydney Smith's discovery of Macaulay's brilliant flashes of silence, when he would resent any attempt at getting into conversation with him.

In another patient (No. 13) the paraplegia, which followed a mild degree of frost-bite, was an unconscious compensation for having been, in his opinion, overworked at trench-digging and road-making.

Compensation has a wide scope in mental life. For example, persons who are pedantically accurate in their choice of words, dealing sledge-hammer blows at any, even the slightest departure, from meticulous verbal accuracy, have not infrequently been found to be grossly careless as to their facts, or distorting the facts and juggling with quotations to meet their own ends. Not only the Puritans

> "Compound for sins they are inclined to
> By damning those they have no mind to."

COMPROMISE FORMATION IN HYSTERIA.

The hysterical manifestation is, according to Freud, a compromise between a repressed wish and an inhibition; the result of a mental conflict between the ego

9 "Collected Papers on Analytical Psychology," by C. G Jung. Translation edited by Dr. Constance E. Long. London Baillière, Tindall & Cox. 1916. P. 280.

and the gregarious instinct — termed by Mr. W. Trotter[1] the "herd instinct." A good instance of this compromise is furnished by

No. 54, a young Australian private, aged 19, suffering from what Captain A. D. Griffith[2] has termed "War-amblyopia."

He was admitted for loss of sight in the right eye, with normal vision in the left. There was a right ptosis present from childhood. He had been seen by Colonel Purves Stewart and by the eye specialists, Captain M. M. Townshend and Captain Griffith. In the right eye on January 7th there was perception of light and nothing more ; the defect had begun on November 15th. This is the history he gave me : On November 15th he was sniping through a loophole when an enemy bullet knocked a piece off the stock of his rifle. He continued at his post; five shots later another bullet struck the sand around the loophole. The right eye began to water. He shut the loophole and went away for an hour. He then returned, the eye being better, opened the loophole, posed his rifle, and then found he could not see the sights on the rifle. There was obviously nothing to do but go to the doctor. The vision got rapidly worse, and in a few hours he had lost perception of light. Let me add that he was a lad of great, almost reckless, courage and of great independence of spirit.

This Australian is a type with the gregarious instinct highly developed—his soldier's quality is strong. A bullet hits the stock of his rifle whilst sniping—the enemy have located him. It must be remembered that he is sniping, so that to go away would have been quite allowable. But he does not give up. Then another bullet comes along. The unconscious, acting on behalf of the ego instinct, sets the eye

1 The Herd Instinct in War and Peace.
2 *The Lancet*, June 24th, 1916. p. 124·6

awatering, forcing him to relinquish his post. Then the soldier's instinct asserts itself, the eye ceases to water, and he returns to the loophole. But here the egocentric instinct, self-preservation, reasserts itself, and the unconscious adopts a stronger attack. He is stricken blind in the shooting eye (note, also, that it is the seat of a congenital deformity). He is now unable to carry out his conception of the soldier's duty, and without loss of self-respect is able to retire, his safety guaranteed. Shall we say that the compromise ends with the odd trick in favour of the egocentric instinct? Even so, it will be granted from the measure adopted by the unconscious that he must have been a first-class fighting man. Blindness has always been regarded as one of the direst calamities that could happen to youth, and for some weeks he had believed that his right eyesight was gone.

DUMBNESS TO DODGE THOUGHT.

Another instance of mutism originally due to conflict is that of case 39, described on page 29. Just before the shell explosion which threw him into the air and rendered him unconscious, his mate, with whom he had just been talking, a man he knew in England—the two had enlisted together—was killed immediately in front of him. It was an explosion not dissimilar to the one he had been through in a pit in England eight years before, when his brother (seven years older than himself) was killed in a pit explosion, the patient escaping but remaining quite dumb for 15 months. Investigation showed some rivalry between the brothers that had continued from childhood, side by side with much brotherly affection and interest in each other. He had often wished that he had no brother or that he would go away, or he would weave phantasies of what might happen were his brother very ill or dead.

The death of his brother and his own escape seemed to him as if he had been making his thoughts real, a conception as Frazer has shown common in primitive man. His guilty conscience will prevent any such wicked thoughts arising anew by taking away speech altogether. He remained dumb for 15 months; time did not permit any full investigation so that it is impossible to say what eventually brought about recovery. The circumstances under which the mutism recurred are of the same type as the earlier instance. The friend who was killed almost by his side repeats the history of the brother's death; there is a revival of the feelings which had never been disposed of in consciousness, and therewith the primitive belief that if ideas are not expressed in words they have not really been in the mind; the dumbness was here an endeavour to dodge thoughts which came up unbidden and whose origin remained, of course, unknown to the patient—even after recovery. Another primitive idea lay at the back of the resistance to treatment; the feeling that the affliction was a punishment sent by God to be removed in God's good time, when the sinner was fully repentant.

DEAF MUTISM AS A WISH-FULFILMENT.

Mutism can have other causes; No. 36 was in the trenches with a mate with whom he had enlisted in Australia; this friend of many years standing was killed by a machine-gun fired a yard in front of him. He lost his head that day and felt unbalanced. He felt he must get outside the trenches and climbed on to the parapet, whence he was pulled back by the sergeant several times. Two days later, after a shell explosion a yard away, by which he was partially buried, he lost consciousness. He recovered some days later to find himself on board ship; he could neither speak nor hear and could hardly stand on his legs.

Under hypnosis he could recall whispering a few words as he was being carried on board and had then again relapsed into unconsciousness.

The wish for death can be gathered from this history; the attempt to climb on to the parapet which was described by himself as suicidal; the relapse into loss of consciousness (taking the original loss of consciousness as due to *commotio cerebri*); the inability to stand; the deaf mutism which outlasts the other symptoms as the wish for death weakens, death which severs communication between man and his fellows and is well symbolised by deafness and speechlessness. Sometimes (No. 35) mutism by itself is the symbol of this wish for death, to have done with the horrors of the battlefield. It will be gathered that this is quite consistent with bravery in the battlefield or in the trenches, each representing partial elements in the man's mental make-up.

Of course, if any investigator were stupid enough to ask such patients did they want to die, they would properly answer no; they might even say they had never thought of it, although closer investigation will not infrequently show such a thought had been present, though perhaps but fleetingly. Clearly the wish for death is incomplete; they do not die, they only more or less simulate death.

PARAPLEGIA AS A WISH-FULFILMENT.

In No. 10 the paraplegia was a wish-fulfilment. This patient was invalided to Malta for mild frost-bite in the toes of the left foot. During this treatment he suddenly lost power in the left lower limb; on being transferred to an infectious diseases hospital (for scabies) he lost power of the right lower limb. On examination seven weeks later there was a stocking analgesia of both lower limbs, which were somewhat rigid. There was a rapid clonic tremor of the anterior

thigh muscles. All the limbs could be moved moderately as he lay in bed. Gait feeble and shuffling, using two sticks and almost bent double. Knee jerks exaggerated, with tendency to right ankle clonus. Plantar reflexes absent at toes. All muscles reacted normally to faradism.

On December 31st the patient was dressed, waiting in the hospital grounds for embarkation to England, as a cot case, the left leg being useless. He had reported the scabies that morning. Then the order for embarkation was cancelled; he was carried back to the ward and transferred by ambulance the next morning as a "walking case" to the infectious diseases hospital. He was able to hop into the ambulance, but at the other end, some twenty minutes' drive, he was unable to walk, the right leg had lost all power in the interval.[3] He thought he was not receiving proper attention, and wanted to show that he really was ill. Hence the paraplegia. It was not malingering; the analgesia and the alteration in the reflexes showed this, as did the patient's gallant attempts to walk. Under hypnosis, although complete movements of the legs were obtained, walking could not be suggested; after the second seance, when he had managed a couple of steps unsupported, he had an attack of "grande hystérie." It was under hypnosis that he expressed the thought that it was unfair to send him as a walking case when the day before he was a "cot"—and his leg was no better.

Hypnotism was given up, as the patient was not making any improvement; instead I made an appeal to him, rousing an emotion that ended in a

3 It was of course quite in order that he should go to England as a cot case—this meant he would be carried from the ambulance on to the lighter and thence to the hospital ship. And of course he was quite suitable as a walking case for transfer from one hospital to another.

flood of tears. He lay awake all that night making up his mind that he would walk, and the next day the sticks were relinquished; he was cured of the paraplegia. The analgesia had been progressively disappearing in the way typical of hysteria. The reflexes became normal. The recovery was helped here by the presence of another paraplegic (hysterical) No. 12, who had been subsequently admitted to an adjoining ward and had made a quick recovery.

THE ŒDIPUS MYTH.

Freud took the Œdipus myth as the type of the infantile relationship to the parents. Œdipus is the archetype of the son's unconscious incestuous love for a mother and rivalry with a father. I am inclined to regard this relationship in a rather different light. Though in the phantasies or dreams of the adult one gets evidence of this love towards the mother and rivalry towards the father, this is rather to be viewed as symbolic of a desire to return to the infantile dependence upon the mother and the undisputed claim to her whole care and tenderness, the rivalry towards the father symbolising the resentment at the interference with this relationship. The deaf mute, described on p. 69, is a typical instance, where the brother simply stands as the surrogate of the father.

The following case of loss of memory is an example of this infantile relationship to the mother.

No. 79 had been suffering from complete loss of memory for six weeks. When admitted he had a vacant blank look, he did not know his name, and could only answer "yes" and "no." His memory recovered completely. The interest centres in the memories that immediately preceded the amnesia. He was only 17 when he was in Gallipoli; he was invalided, and it was whilst convalescent in Malta that the

attack came on, when he was visiting some friends just at Christmas time. Mrs. X., a motherly, kindly woman, was baking some cakes. His thoughts travelled back to his people's home at Christmas, to his mother. Then he saw himself, a child of five, making cakes in the kitchen alongside his mother. He saw himself putting one of the cakes on paper in the oven. The cake was burnt, but "I ate it myself all right, taking some strawberry jam out of the pot for the cake." A little later he was very dizzy, with a terrible headache; a friend took him back to camp, where it was at first thought he was drunk. But the medical officer who was sent for of course recognised his condition. He offered a piece of cake (from his store) to the doctor the next morning, although without being able to give any explanation. This amnesia was clearly an attempt to blot out all the surrounding associations with the war, to keep this lad back amid the happy experiences of childhood. These and many other scenes which were reproduced in hypnosis were immediately told him on awaking; and very soon memory returned for the whole period. There were other events, unsuitable to repeat here, which showed that certain other responsibilities had been placed upon him which were too much for his age.

But that under sufficient stress of circumstances there can be at any age a return to this infantile adaptation may be read in the following sketch:—

A sergeant (No. 26), 34 years of age, had been 16 years in the army; he was wounded in the left frontal region by shrapnel. He was unconscious for 12 hours. About two weeks after the wound had healed he lost power in the right hand. When he came under observation, six weeks later, there was subjective and objective feeling of cold in the right hand (he wore a glove), and a "tingling feeling as of a mild

electric current" ; analgesia-anæsthesia to 3 in. above wrist ; loss of power in hand ; grasp feeble ; could not fully flex fingers ; was unable to hold things in the hand ; could not write with this hand. He was to some extent ambidextrous by training. He batted and shaved with either hand but was a left-hand bowler and a right-hand writer.

With suggestion under hypnosis all abnormal sensation disappeared and normal sensation returned ; the hand recovered its power. He gave a rather interesting exhibition of rationalisation.[4] One day, under hypnosis, I told him to write home to his mother. He was unable to carry out the suggestion post-hypnotically, telling me he had tried to write but his hand was too tired. I then told him (again under hypnosis) to write me a letter. The next day he handed me a well-written letter. I thanked him and said, "But why did you write me since I see you every day ?" He replied, "I thought it would be nice to show you how I am getting on." He was quite unaware of my suggestion and consciously he did not know whence came the impulse to write. As is so frequently the case, consciousness proceeds to find a rational motive, a mental process which should put us on our guard not only in our dealings with others. The advice given by Lord Mansfield to a newly-appointed judge will be remembered : "Give your verdict, it is pretty sure to be right ; never adduce your reasons—they are equally sure to be wrong."

The paresis in the right hand had occurred suddenly one day just as he was about to write a letter to his mother. "I could not hold the pen ; there was such a tired feeling in my hand." (This persisted until treated.) He was about to write to his mother

4 See Ernest Jones : Rationalisation in Every-Day Life. Papers on Psycho-Analysis. London : Baillière, Tindall & Cox.

that he thought she need not be worried about the condition of a younger brother who had become a wreck after a bomb explosion at Y. The brother would get better in time. He was not going to mention his own injury as he did not want to worry her. Under hypnosis he admitted that he would have very much liked her to know about his accident, he greatly wanted her love and sympathy.

Altruism, the wish not to give additional distress to his mother, is here in conflict with the egocentric impulse. Here again the hysterical symptom arises from a compromise between two opposed affective impulses just as we saw in the case of the Australian sniper, described on page 67. Paresis of the hand prevents the gratification of either impulse, but with the balance in favour of the more primitive instinct, since his illness is now more severe, and his mother must be written to by a third person who tells her of her son's condition. *But he does not write about it himself.*

The history of this soldier of 16 years' service all over the world shows how powerful was the maternal allegiance. He had never been interested in any woman, had never been engaged or even condescended to kiss one, not even to hold a strange woman's hand "so very little longer." He had once won a few hundred pounds in a lottery and had sent it home to his mother. I said to him, "I suppose after the war you'll marry." "Not while there's mother to look after." His father, I should add, was alive, and they were not in bad circumstances. This history is sufficient to understand the origin of the paresis; any deeper analysis of the hysteria is not my purpose here. But I would point out that this is another case in illustration of the thesis that hysteric must not be read as degenerate. This patient is neurotic, but he is a fine soldier, who had served in the South African War, where he had been slightly wounded;

a shell explosion had blown him up whilst in France, for which he was invalided for four months, and he then went to the Dardanelles. He is an N.C.O. of charming manners, of good intelligence, and a "neurotic."

CHAPTER IV

ANXIETY-HYSTERIA

WHILST in conversion-hysteria the most prominent clinical symptom is somatic, in anxiety-hysteria the most prominent symptoms are mental. A feeling of anxiety, dread without adequate cause, a nameless terror or some phobia, intense exhaustion after the most trivial mental or physical effort, distinguish this class of case; sleeplessness and headache are common, whilst sensory motor disturbances, though frequently present in the form of some analgesic area, may be absent.

The phobias and obsessions are of the most varied kind; Withermann[1] says the desire for the Iron Cross is often of an obsessional nature. Steiner[2] cites the case of an N.C.O., a congenital psychopath, who would not let his company fire upon the enemy in consequence of the "obsession" that the enemy men had women and children dependent upon them. He was affected by a constant taste of blood and a smell of corpses. Binswanger[3] mentions a similar case of "obsession" where the following dream dialogues were overheard: "Do you see the Englishman there?" "Has he got parents?" "Has he a wife?" "I won't shoot him dead—"

1 Withermann quoted in Zeitschrift für die gesamte Neurologie und Psychiatrie. Band 12. Heft. 4. March. 1916.

2 *Ibid*, p. 30. H. 2/3. 1915.

3 Hysterosomatische Krankheitserscheinungen bei der Kriegshysterie. Monat. f. Psych. u Neurol. 38. Heft. 1/2. 1915.

Vaso-motor disturbances invariably accompany the feeling of "anxious dread," which is perhaps the best term one can find. These vaso-motor symptoms are many and various; all the physiological systems may be disturbed, though not all may be affected at any one time. The commonest of these disturbances are:—

a. CIRCULATORY.—Already described on page 42 under the "Soldier's Heart;" congestion of the extremities aping Raynaud's disease.

b. RESPIRATORY.—Feeling of suffocation, breathlessness, air hunger, dyspnœa, hay fever, asthmatic conditions.

c. INTESTINAL.—Anorexia, vomiting, indigestion—colic—diarrhœa—(constipation more rarely).

d. EXCRETORY.—A sweating, especially of the palms, urticaria—transient œdemas—pollakuria, colicky pains over the bladder.

e. NERVOUS SYSTEM.—Headache, parœsthesias, photophobia, hyperacusis, disturbances in the sense of smell and taste.

f. MUSCULAR SYSTEM.—Tremors, generally fine and often confined to the hands.

The thyroid is not frequently enlarged, sometimes with slight exophthalmos; more rarely the ocular symptoms seen in Grave's disease are found.

The blood count may show a total increase of the white cells with a lymphocytosis.

The following is a fairly typical example of this kind; it is a case of

REPRESSION OF FEAR.

No. 84. The patient, aged 25, who had gone through the Gallipoli campaign without a scratch and, as he said, with practically no fears was later frost-

bitten in Salonica. He was sent to hospital on December 18th. When he came under me on February 7th the finger of the right hand was well, but there was some loss of grip. He was then suffering from insomnia, terrifying dreams, and tremors of the hands. On December 6th at K——, when holding horses on a flying bridge the animals started and he was thrown into the water; he was picked out none the worse. The next day it happened that his horse was shot under him, but he escaped. A few days later the middle finger got frost-bitten, and he was sent to hospital, where his hands began trembling, sleeplessness came on and severe headaches.

The patient was a thick-set sturdy fellow, jovial and kindly, the son of an agricultural labourer. The thyroid was diffusely enlarged, but there were no ocular signs of Graves's disease and no signs of disease in the central nervous system, other than the tremors. The blood pressure was high. There was a fine tremor of the hands, six to the second. The pulse was irregular and rapid, and there were not infrequent attacks of cardiac palpitation — almost anginal in character.

Blood examination.[4]

Total white cells, 11,500 per cmm.		
Neutrophile polymorphs,	48	per cent.
Lymphocytes, small,	47	,,
Lymphocytes, large,	3	,,
Large mononuclears,	2	,,

The extremities were cold and blue (only one finger on one hand had been frost-bitten), he sweated violently in the palms, there was hyper-sensitiveness to sound, occasional attacks of dizziness and a feeling of suffocation, making him gasp for breath. There was frequent desire to micturate.

4 I am indebted to Major Arkwright, R.A.M.C., M.O. i/c of the Pathological Laboratory, for the examination of the blood in this and the other cases.

This is very much like the description of a severe state of fright, such as many have experienced in the Examination Hall, when the hands get a little tremulous and the palms sweaty; and, as we know, these dreadful infernos are provided by some thoughtful architects with extra latrine accommodation.

His terrifying dream was always the same. "I see a Frenchman digging a knife into a *horse*. He gets off his cart to do this. It is in Serbia." Not only at night but during the day this comes up as a vision. It is an actual occurrence. He saw a French transport soldier, drunk, get off the waggon and plunge a knife into a *mule* to make it go. With some others he stopped the Frenchman and drove the waggon into quarters. (Note, the mule becomes a horse in the dream.) The patient's feelings about horses were very intense. He had been used to horses since childhood; his earliest recollections are of driving with his father or of being put up on the plough-horse. As a boy he was engaged about the stables and later became a groom. He wept profusely when talking to me of the sufferings experienced by the wounded mules in Gallipoli, and when I suggested that human beings suffered more he would not have it so. Animals could not talk. No animals should have been allowed there, he said. He never had any trouble with horses, for he understood them exactly, and he was always given the difficult ones to manage. In short, he was as doting on horses as any maiden lady over her Fido.

We suspect all exaggerated sentiments; with Queen Gertrude we feel "The lady doth protest too much." Investigation soon showed that the suspicion was justified. He identified himself with the horse. He was the horse of the dream; it is he who ought not to have been in Gallipoli—it is too much for him and others. Consciously the soldier instinct in my patient

would know no fear for himself. But as the Latin satirist says :—

"Primus in orbe deos fecit timor."

Fear is a primary, natural instinct, and, like murder, will out. So long as the patient was actively engaged looking after the horses he could expend all his mental excitement in pity for them—*i.e.*, himself. But condemned to inactivity by the frost-bitten finger this mental excitement (which even before had been abnormally expressed) finds no outlet, emotionally or actually. Could it have reached consciousness the patient would have been able to deal with it, as he subsequently did with our help. Such cases are often due to fear—not necessarily fear of shrapnel—thus bottled up, or repressed from consciousness. This fear not being acknowledged or worked off becomes morbid fear, morbid because it is no longer objective.

That the person should become a horse in the unconscious will not startle anyone who has dipped ever so little into the totems and taboos of the lower races. The kangaroo tribe, for instance, as Sir J. G. Frazer[5] shows, consists of kangaroos and kangaroo men, who actually are kangaroos and delight to show their identity by identity of action. But, indeed, it is not necessary to travel to Australia. Which of us has not galloped as a horse, pawed the air, impatiently neighed, and chafed at the bit. And when some day our child comes galloping into the room, kicks over a

5 "In the Alcheringa lived ancestors, who in the native mind are so intimately associated with the animals or plants, the names of which they bear, that an Alcheringa man of, say, the kangaroo totem may sometimes be spoken of as a man-kangaroo or as a kangaroo-man. The identity of the human individual is often sunk in that of the animal or plant from which he is supposed to have originated." Spencer and Gillen ("Native Tribes of Central Australia," quoted by J. G. Frazer, *loc. cit.*, "The Magic Art," Vol. I., p. 107); "There was no sharp line of distinction drawn either in theory or in practice between a man and his totem."

chair, and seizes some food from the table with his teeth—we understand. We do not say, "Don't, Dickie," but we pat the mettlesome steed on the head, feed him from the hand with lumps of sugar and bits of apple; we softly rub his nose. We understand. The father is no longer everything that is wonderful in strength and power; there are other great spirited creatures too. And, perchance, we silently pray: May all future adaptations be as gleefully and successfully accomplished, as happily understood by ourselves, and as little thwarted.[6]

This patient recovered under treatment; sleep returned, he ceased to be disturbed by this particular dream and vision, and therewith the physical symptoms subsided. In this case unfortunately no second blood-count was made, so it cannot be said if any change is to be recorded. In another case, however (No. 60, see p. 38), there is a record of the blood-counts made when the patient first came under treatment and a fortnight later, when he was much improved; the facial tic had then ceased, the eyesight was normal, and the vaso-motor symptoms (sweating, pollakuria) troubled him no more.

Count on March 17th, 1916.

White cells, 14,000 per cmm.		
Neutrophile polymorphs,	40	per cent.
Small lymphocytes,	43	,,
Large lymphocytes,	13	,,
Large mononuclears,	3	,,
Transitionals,	1	,,

March 31st, 1916.

White cells, 10,750 per cmm.		
Neutrophile polymorphs,	35	per cent.
Small lymphocytes,	32	,,
Large lymphocytes,	16	,,
Large mononuclears,	13	,,
Transitionals,	4	,,

6 For a deeper significance of the symbolic meaning of the sacrificial horse consult Jung; "The Psychology of the Unconscious," p. 311-316.

The total number of white cells was much nearer the normal, as was also the percentage of small lymphocytes, but I am not competent to discuss the physiological significance of the blood changes in these states.

Though it does not come within the scope of this book to treat in any detail of the relationship between the mind and body, there are a few points which must here be touched upon.

In the patient No. 84 we have repressed fear, with certain vaso-motor signs seen in the emotional state of fear, enlargement of the thyroid, and alterations in the constituents of the blood. Cannon[7] has shown experimentally that "clear evidence has been secured that in pain and deep emotion the glands [adrenal] do, in fact, pour out an excess of adrenin into the circulating blood." He has shown that the adrenin thus poured out in pain and fear produces exactly the same effects that follow an injection of adrenin. "Here, then, is a remarkable group of phenomena—a pair of glands stimulated to activity in times of strong excitement, and by such nerve impulses as themselves produce at such times profound changes in the viscera; and a secretion pours forth into the blood stream by these glands, which is capable of inducing by itself, or of augmenting, the nervous influences which induce the very changes in the viscera which accompany suffering and the major emotions" (p. 64). "When adrenin is injected into the blood it will cause pupils to dilate, hairs to stand erect, blood vessels to be constricted, the activities of the alimentary canal to be inhibited, and sugar to be liberated from the liver" (p. 37).

Cannon also suggests (p. 63) that adrenin may

7 "Bodily Changes in Pain, Hunger, Fear and Rage," by Walter B. Cannon. New York and London: D. Appleton and Co., p. 64.

co-operate with the products of other glands of internal secretion; the other glands of internal secretion may be stimulated by sympathetic impulses (p. 65). We have indeed clinical evidence that the thyroid is changed in these emotional states. It can be hardly otherwise, seeing the inter-relationship of these glandular secretions, than that there is a stimulus of all the glands, the glandular equilibrium being disturbed throughout.

It is then conceivable that the alteration in the blood cells, the lymphocytosis, is in these cases a secondary consequence of this repressed fear or other emotion. "If these results," says Cannon,[8] "are not 'worked off' by action, it is conceivable that the excessive adrenin and sugar in the blood may have pathological effects." I have shown that the emotion was not worked off in this patient (No. 84).

The mental condition would be the primary cause of the disease, but it does not follow that treatment would necessarily remove at once all the remote effects set up. Treatment directed to, say, any of the symptoms, *e.g.*, the enlargement of the thyroid, can produce excellent results, as Dr. Florence A. Stoney[9] has shown; if the hyperthyroidism is subdued, the vaso-motor symptoms, which are due to the disturbance in the relationship of the internal secretions, will disappear. It seems not unlikely that the treatment by X rays, of which she is a strong advocate, likewise may influence favourably the primary cause, the mental condition. These patients, as will be gathered from No. 84 and the others who were cured or improved by suggestion, were extremely suggestible.

8 *Loc. cit.*, p. 196, footnote.

9 Proc. Roy. Soc. of Med., l.c.; Section of Therapeutics, p. 50

SOMNAMBULISM.

It is difficult in some cases to differentiate a somnambulism from that more extensive dissociation of consciousness known as multiple personality. The difficulty arises in the following case, more especially because I lacked the opportunity of seeing the patient in any of his more pronounced conditions.

No. 77. Aged 31, a private in the R.A.M.C.

Anamnesis. In autumn of 1914 the hospital to which he was attached in France was shelled, and he began to suffer from headache and exhaustion. In January, 1915, he was invalided for "neurasthenia." In April, 1915, he was sent for duty to Malta. In August, 1915, he had an attack of sunstroke, dropped down unconscious and lost his memory for seven to eight hours. After 14 days in hospital he was sent back to England. In November, 1915, he returned for service to Malta, and whilst on hospital duty in February, 1916, he repeatedly wandered out of the tents at night and "lost himself" for some hours. These fugues had become very frequent of late. He was brought before his O.C., who at once sent him into hospital as a patient.

Examination a few days later:—

Frequent myoclonic spasms of left face, neck and shoulder girdle, much less marked in the left lower limb. Constant shrugging of left shoulder. Pupils R. > L., they react normally. Contraction of left visual field. Loss of smell (tobacco) in left nostril, and of taste (salt, sugar) on left side of tongue. Hearing less on left side than on right. A complete left hemianalgesia. All the movements of the left upper limbs are feebler than right and associated with increase of tremor.

There is pain over the cardiac region with palpitation and breathlessness. Tachycardia was noted with

a rapid irregular pulse ; occasional attacks of dyspnœa which are relieved by drawing a succession of deep breaths with a loud sigh in expiration. There is increased frequency of micturition, but the total amount of urine passed in the 24 hours is not excessive ; the urine is normal.

The gait is normal.

All the reflexes are brisk and equal.

He suffers from intense pains over the back of the head, especially on the right side ; he sleeps badly, dozing for a few minutes and waking up with a start and in a profuse sweat. The nights are disturbed by nightmares and terrors. He complains of loss of memory and of inability to concentrate his attention either in conversation or in reading. A walk of a few yards or the reading of a few lines completely exhausts him. He is in great fear that he is "going mad."

He is happily married and has three children.

The amnesia is complete for the earlier years of his life, and selective for later periods. There is a complete loss of memory of everything up to the age of 11. He knows that he then left G. for a large town in the North of Ireland where he still lives. But he remembers nothing of G. ; whether he went to school there, the kind of house he lived in and so on. From that time up till the war the memory is good, yet with certain blanks as to dates, *e.g.*, the year of his marriage. He could not at once say how many children he had nor their names. He had forgotten the name of his employer with whom he had been for some years. The patient was the manager of a cinema and was in daily association with his employer on the most friendly terms. These lapses of memory would obsess him, and he had various devices for overcoming the difficulty. Half a night he lay trying to think of this employer's name and then recollected he had a

photograph with his autograph. The name was a very common Scotch name, and was also that of a physician who had seen him in Malta in August, 1915, and invalided him back to England. The physician's name was well known to the patient at the time of his illness. There were also defects of what Mercier[1] calls the practical memory, and to some extent one could say of this patient what Mercier writes of a case he quotes: "It is for future things that his memory is defective." An instance of this loss of practical memory, or apraxia, was his inability to strop a razor and although shown he would be immediately at a loss how to do it. (He was able to shave himself.) He did not know how to lace up his boots, and he would forget all appointments in regard to his work as an orderly, the hours of meals, etc.; the want of memory made him oblivious to the shoulder tic and the tremors. As he himself said, he forgot all about it till some one would ask him how his shoulder or face was. One could almost say that he forgot to see with the left eye, to hear with the left ear, to smell with the left nostril.

On several occasions the content of consciousness had been abruptly broken and the patient possessed by a quite new stream of conscious ideas. Such a somnambulism occurred for instance on his return to duty in April, 1915. He had left D—— in Ireland overnight on his way to Aldershot; in London he had several hours to wait. Walking about he suddenly found himself in V—— Street, D——, with the Opera House in front of him. He crossed over to a fruit shop which he knew well, as it was at the corner of his own street (in D——) and was kept by a friend of his, Mr. (let us say) Leary. He went in and asked for Leary. The fruiterer knew nothing about Leary and a slight altercation arose; he thought they were

1 "A Text Book of Insanity." 2nd edition, 1914, p. 106.

playing a stupid joke with him. He crossed back to look at the building and was dazed to find it was a blank wall. He asked some ladies passing him what had become of the Opera House and then his mind became quite blank till he awoke, quite himself, the next morning in the police station. The police had taken care of him overnight. He proceeded to Aldershot. He was told about the incidents of the previous night and understood objectively what had happened, but he had never yet been able to fit the events into the stream of his conscious life. It was no more to him than if he had read a similar curious story in the newspaper.

He was not feeling well when he received orders to report for duty. He was in a condition when, as Mercier[2] puts it, "the states which should normally be subconscious are thus lifted into the light of full consciousness, and become subjects of attention without direct guidance from the will, which is otherwise engaged." It is easy here to read into the state thus lifted into full consciousness a wish-fulfilment. He wished to be at home in D——; he was at home in D——; a fruit shop became the fruit shop kept by his friend Leary at the corner of his own street; the blank wall had become the Opera House of his own city.

On another occasion, prior to his return to Malta in November, 1915, he had been three weeks in Aldershot, when one night, about ten o'clock, he dressed himself, put on his overcoat, haversack and water-bottle, and reported himself in the guard room as having just arrived. He gave his name correctly, drew his blankets, etc.; on leaving the room he was recognised and conducted back to his room. He awoke the next morning with complete amnesia of

2 C. Mercier. Discussion on "Imperative Ideas." Brain. 1895, p. 329.

the incident of the previous night. "The next morning I was told about it and was frightened of myself."

A few days later the same thing happened, when he was recognised by an orderly in the guard room.

Here again we see the wish-fulfilment, the endeavour to blot out the three weeks in Aldershot.

After the shelling of the hospital in France (April, 1915), he had several hysterical fugues, wandering from the tents and hospital and "coming to himself" some distance away, ignoring how he arrived at the spot, the intervening period a complete blank.

Minor instances of such lapses of memory were of frequent occurrence. In a word-association test[3] carried out with this patient, he, on one occasion, gave 68 per cent. of meaningless reactions and "faults," and a fortnight later 41 per cent.

The percentage of meaningless reactions and faults among normal men of his own class is between 0.9 and 2.4.[4]

By a meaningless reaction is understood a reaction which is either not a word at all or not an association. The non-associated words are frequently the name of some object in the room, as in this patient. A "fault" means the absence of a reaction altogether. Thus, a series of reactions with this patient ran:

Stimulus-word.	REACTION.
Head	Pin (one was on the table).
green	watch (one on my wrist).
water	button (on uniform).
Pink	Pembroke (name printed on a box in the "bunk" where test was conducted).

3 For the technique of this test, see "The Association Method" in Analytical Psychology. *Opus cit.*, p. 94, *et seq.*

4 "The Associations of Normal Persons," by Jung and Riklin; Chapter II. of "Studies in Word-Association," edited by Dr. C. G. Jung, translated by Dr. M. D. Eder. London: William Heinemann. (*In the Press.*)

Stimulus-word.				Reaction.
angel	...	...	...	———
ship	...	...	...	sea.
pick	...	...	...	orderly.
wool	...	...	...	———
town	...	...	...	cigarette (I was smoking).

This patient had made his own way in life; he had a rather forceful personality and a great love of independence. His father had been a schoolmaster in Scotland, had then gone into a business in Ireland which had been a failure. Soon after the age of twelve the patient began to earn a living and at a very early age he was the main support of his parents. He was the youngest of the family, the other brothers and sisters had been better educated than himself and were all in far better circumstances. He was not on friendly terms with them. His father had died some years ago, but his mother, still alive, remained a member of the household. Although he had been in many trades he succeeded best in work that was connected with the theatre, and for many years he had been engaged in some way with theatrical life. Super, actor, box-room attendant, pay-office, and finally manager of a cinema. Only in this way was he happy in his work.

Sublimation.[5] The peculiar attraction the theatre had for him showed itself to be the sublimation of infantile exhibitionist tendencies.

REGRESSION OF THE LIBIDO.

To a man of this temperament the necessary army discipline was more than irksome. He was a "unit," his individuality felt swamped. There was no outlet

5 The replacement of infantile and childish impulses by corresponding adult outgrowths subserving more altruistic and ethical purposes is called *sublimation*, when this development takes place as normal growth from within, and not by compulsion, by authority or external pressure. There is no "repression" in successful sublimation.

for the display of his personality, for the sublimation of his exhibitionist tendencies. His not to reason why, his but to do as he was told—and told by others whom he regarded, whether rightly or wrongly, as inferior to himself in intellect and character. It must not be supposed that this represents the patient's conscious attitude or that he was in any sense fractious or insubordinate. Quite the contrary; from independent witnesses (he had been an orderly in the hospital) I was able to gather that he was most faithful in the fulfilment of his duties—a model orderly in every way—until his health broke down; he had never voiced any complaint. The conflict raged within, and being debarred from reaching consciousness, owing perhaps to the patient's unusually high sense of duty, it found vent in phantasies. Jung [6] says, "If the individual consciously or unconsciously allows the libido (psychical energy) to turn away from a certain essential task the non-used up libido occasions symptoms of a painful nature, oppressing the individual at every turn."

The wish to regain his feeling of lost individuality expressed itself in these attacks of somnambulism when he broke the chain of consciousness that bound him to the army by the temporary assumption of his former self. In the attack he was out of the army, he was back again in his former life, he was the theatre manager or filled another of his favourite *rôles*.

A dream shows this desire for individual distinction.

"*I was in France at some hall or theatre, a hypnotist was on the stage with me. He asked for volunteers. I went . . . a lot of bugles. I was called to put out a fire.*"

6 "The Theory of Psychoanalysis," by C. G. Jung. New York: Nervous and Mental Disease Publishing Company, 1915.

The patient had once taken part in a rescue from a fire and his name had appeared in the local paper. The other associations showed that the fire stood for the display of individual energy, passion. (He knew that I used hypnotism in the treatment of some patients.)

The dream is an unconscious demand from those in power to allow him to regain his individuality; he wants to be called upon to display himself, to be a leader.

THE CHOKING OF THE LIBIDO.

Among the common symptoms in this choking of the libido is a return to infantile and childish phantasies, a regression to an earlier adaptation possibly long since abandoned, as in this case. A dream showed us in what infantile phantasies the libido was now engaged.

"*I was going to be hung. I was working at some hospital in France, with a German patient. I shot him with a revolver. I was put in a cellar and was brought out to be hung.*"

The German patient turned out to be an older brother; the rest of the dream was a typical one and will be understood by those acquainted with symbolic language. Its full explanation would require a detailed exposition that would take us beyond the scope of the book. The last dream he brought me in analysis, just before he was transferred home, ran:—

"*I was carried on a stretcher to the eye bunk and you were there, but you went out and left me. I tried to run after, but could not move any part of me.*"

(My work was carried out in the "eye bunk.")

The analysis showed that this paralysis expressed his double-sided (ambivalent as Bleuler calls it)

attitude towards leaving me. He wanted the treatment to continue, so that in the dream he is very ill and must be carried. (The patient was really up and dressed.) I leave him, it is my fault, as it were, that his treatment is to stop. He wants me. But he also wants to go home. Hence the paralysis—a mental indecision.

The shrugging shoulder (again left-sided) turned out to be a rather unusual form of symbolic conversion. It expressed disapproval of his own unconscious phantasies.

The patient was under psycho-analytic treatment for four weeks; this had resulted in improvement in his symptoms. The hysterical stigmata had left, the tic was much less frequent and violent. His burning headache had ceased and he was sleeping better (no hypnotic drugs had been given throughout). The somnambulistic attacks had gone and he was beginning to concentrate; he could read a paper and write a letter; he brought me some verses he had written.

But the analysis was incomplete, and the patient's unconsciousness had recognised, as his dream showed, that he was not cured and required further treatment. I feared he would relapse before very long. Such improvement is not infrequent in the early stages of analysis, and has too often deceived both patient and doctor.[7]

7 I heard from this patient some time later. He was still in hospital having a rest cure! Some of the symptoms, as I feared, had returned.

CHAPTER V

PSYCHASTHENIA

THE name given by Janet calls attention to one of the most prominent clinical symptoms in these cases, the intense exhaustion, as Freud's term, obsessional neurosis, rivets attention upon another of the main clinical features. I have retained Janet's designation because it is the better known, and had I adopted an unfamiliar name for this group of diseases I should have fashioned one that fastens upon a deeper psychological aspect. But, for reasons already given, the psycho-analysis of none of my patients was complete and the results given in this chapter are too meagre to add much strength to any far-reaching psychological conclusions. Still, some of the analyses do, I think, offer evidence in support of Jung's [1] *introversion* theory as well as to a further conception which I will leave unnamed.

COLLECTING MANIA—FEAR—PSYCHIC AMBISEXUALITY.

No. 95 was living in a north-eastern town that was bombarded in December, 1914. A shell came through the roof of a house where he was staying with his wife, child and father. No one was hurt, but for the next three weeks he was quite "broken down." He could not undress nor go to bed at night, but slept

1 Analytical Psychology, *op. cit.*, p. 347.

fitfully in a chair. He was "all of a tremble" and started at the least noise, breaking into a fit of crying at the slightest provocation or at none. His wife used to comfort him. He gradually got better "in himself" but still felt very nervous and trembling; he was afterwards afraid to drive a motor bicycle or a horse and cart, both used in his business. Nevertheless he felt he must "do his bit" and enlisted in August, 1915, in the A.S.C. motor transport but broke down right away. He was to be retained for home service, but implored his C.O. to give him a chance of serving abroad. He was sent to Salonica. It was found that he was too nervous to drive and he was given work in the stores until, owing to inattention, he made some mistakes and was kept for odd jobs, such as clearing the rubbish away round the tent, removing stones. He had a fit and was sent into hospital.

When he came under observation in February, 1916, he was suffering from sleeplessness, inability to fix his attention, terror so extreme that if a motor went by the hospital grounds he would scuttle under the bed. With difficulty could he be persuaded to take off his clothes at night; he had a "collecting mania," having gathered several bags of cigarette pictures for his little girl and bags of stones from the shore. The fear of Zeppelins was obsessional. The Sister coming in with a lantern was sufficient to send him under the bed; another obsession was that he would be accused of stealing, *e.g.* his own uniform and boots, since he had done no fighting.

There was analgesia of both legs to the knees and of the left arm to the shoulder. There was no history of previous nerve trouble; he was happily married, in a decent position, a total abstainer; he had often taken part in boxing competitions and cycle racing. (His "legs used to get excited before a fight.")

This patient showed his grit by enlisting voluntarily, against the wishes of his wife, family and friends, and by getting abroad ; a strange contrast with his condition of fear and terror. The following two dreams throw light on this contrast.

Dream. *He was at home dressed as a Highlander and saw his little girl who did laugh—so did he.*

Dream two days later. *He was a Chinaman in native dress, with a long pigtail; beautifully long hair right to the floor.*

No analysis of the dreams was made (nor, of course, any interpretation given to the patient). These are typical dreams of being or desiring to be female. The Highlander's kilt is a disguise under which the endopsychic censor permits such unconscious wishes to appear in consciousness without betrayal. A Chinaman is perhaps more tell-tale ; Europeans proverbially find it difficult to distinguish a Chinese man from a woman, on account of the flowing robes, the lack of hair on the face, etc.; in this dream the pigtail, as if the latent meaning was trying to get expression, was beautiful and long, reaching to the ground.[2]

It is important to note that the "dream-work" aims primarily at disguising the meaning of the dream, or its latent content, from the dreamer himself ; the censor is much less concerned with concealing its significance from third persons. The symbolism here used, though plain enough to myself, was quite effectual so far as the dreamer was concerned. It is probable that if the first of these two dreams had been analysed in the usual way and the dreamer had

2 It must not be assumed that a Chinaman invariably stands for "woman." There might be, of course, some specific memory. I am only dealing with it when it is a universal, not a particular, symbol.

realised its significance, the second dream would not have occurred, or very different symbols would have been used.

The reading of this dream shows, as I have said, a concealed wish to be a woman; he is psychically a woman. This gives the clue to the patient's excessive emotivity, his exaggerated fears, his "woman's" heart that burst out crying if he saw a child in the street. The primitive unconscious is wont to exaggerate any part, especially to overact its popular attributes. If a woman may be regarded, without prejudice, as the lawyers say, as a more timorous creature than the male, then the unconscious repressed female in a male exhibits fear greater than was ever shown by any woman; if a woman is popularly taken or typically regarded as having motherly feelings towards any child, then the female suppressed in the male weeps bitterly over every passing child.

It is a case of ambisexuality, the male side being shown by the desire to share in the fighting. The origin of this exaggerated psychic ambisexuality was not discovered, for no deep analysis was made, though the anamnesis and some other dreams threw some light on the problem.

The "collecting mania" was connected with a money-complex. His father, beginning life very humbly, had amassed quite a respectable sum of money. This patient felt a desire to amass money like his father, to have his father's money—so that there was an under feeling of bitterness and rivalry towards his father. This found conscious compensation in the most exaggerated praise of his father and of the patient's wonderful goodness as a boy and man towards his father, of extreme punctiliousness in money matters; see, for instance, his doubt whether he should not return his pay to the State since he had done no soldiering, which co-existed with singularly

naive reckonings as to how much he would be able to draw by the time he reached England.

The result of treatment by hypnotic suggestion is very interesting; he was easily hypnotised and responded readily enough to suggestion under hypnosis but post-hypnotic influence was for a time altogether absent. His fears remained, his excessive emotivity, sleeplessness, and so on. We continued our psychological investigations (diagnostic psycho-analysis as it may be called) and he brought me the material briefly summarised here together with the dreams. I then used the knowledge, deduced from the psychological examination, under hypnosis, telling him that he was no longer to act the timid female, that his womanly side would quite go, that he was a vigorous male, that he had no exaggerated female characteristics, that he did not want to bear children (another dream showed this phantasy), but to be the father of children and so on.

He re-acted post-hypnotically to these suggestions; from that time (the sessions were repeated) the fears began to diminish and finally disappeared. The next day he proudly told me that he had brushed his boots—the first time since leaving England, nearly two months ago. He no longer scuttled under the bed if he heard a motor-horn; the analgesia disappeared. This case shows the advantage of knowing what suggestion to give in difficult cases; in easy cases, of course, the stereotyped suggestion answers well enough. To obtain the information required for accurate suggestion we can apply the results of psycho-analytic knowledge to our patients' symptoms history and dreams. In the waking state this patient was not aware of the suggestions that had been made to him during hypnosis, upon which he subsequently acted. He knows nothing to this day about the possession of a money-complex, of his unconscious

attitude to his father, or of his strongly marked female side.

FEAR CONTENDING WITH DESIRE

The following is but a fragmentary history; I have included it because, incomplete though it is, it presents a not uncommon psychological attitude.

No. 100 was admitted for physical and mental exhaustion and insomnia. There were no physical signs. All he wanted to do, as he put it, was to lie coiled up in bed; it was an effort to think, it was an effort to eat, it was an effort to turn round in bed; he did not want to become aware that he had legs or hands. It was not the condition of apathy as seen in melancholia. He wanted to lie coiled up in bed, but he could not; he could not prevent himself being stirred into some kind of activity by his surroundings; conversation would trick him, as it were, into a discussion; then he would think this activity was injurious and would fall into silence. "I'm tired out, and though I spend most of my days in bed, it is without rest or sleep." "I feel I have to go through the whole weary business again." "What's your name, age, service—what's the matter with you? Why can't you sleep? I'm simply too tired to bother with it all,"—was his feeling on admission to our department. The patient was 28; he had been married subsequent to joining the army. He had joined the service in the autumn of 1914, his health not being good enough to join at the beginning of the war, and had risen rapidly to high N.C.O. rank. He had seen service in France and the East. He was much worried about the relationship between himself and his commanding officer—a recent appointment—whom my patient believed was trying to get him reduced in rank. That the patient had risen from merit alone was clear; he had no Army friends.

He had been educated at a public school and had afterwards had good appointments in the Colonies, having returned to England two years before the war for family reasons. The work abroad was rather responsible, of a nature calling for much individuality and management of subordinates. It was doubtless to this training, combined with great natural gifts, that he owed his rise.

There had been three similar attacks of illness before the war, in fact he was convalescing when the war broke out.

The family history was medically not good. His had been a solitary life; he had had but one friend at school and later in life found it difficult to get into touch with men and women. Like so many in similar case life never seemed wholly real to him; he had drifted along. With many abilities, he had not hitherto found his niche in the world; "people did not understand him." The home life had not been a happy one; between himself and his father there had always been opposition; he was out of touch with his mother and sisters. He had become interested in ideas and social reforms, especially in sexual problems. Frankness between the sexes he was wont to regard as the first desideratum and he claimed that he had been able to establish this with the one or two women he had known at all intimately; "a platonic relationship" on this basis had been his ideal. He had kept himself pure and had never indulged in the mildest flirtation. He had a horror of sex and he complained that the language of the barrack-room and the camp was filthy. He found that women and sex were the only topics of conversation and it was the one theme he wanted to shun unless it could be discussed in an entirely rational and scientific spirit, as he complained it never was. He had, during his stay in parts of the

world notorious for their license, kept himself unspotted—chiefly, he believed, for a girl whom he had known in England—the first woman outside the home circle he had known; she had been the main factor in bringing him away from the cramped and rather sordid home atmosphere. She (and her brother) had inspired him with ideals of life, had awakened a certain literary instinct and had urged him towards a higher life. There was no question of marriage with this lady, who was some years older, and with her he had never discussed the sexual problem in any way.

On the surface there was this pure and rational attitude towards sex; but beneath there was a raging torrent of desire which had never found any outlet, of course a not very uncommon position.

> "More than I, if truth were told,
> Have stood and sweated hot and cold,
> And through their veins in ice and fire,
> Fear contended with desire."

It was in compensation for this ill-regulated sexual life in the unconscious that he became so horrified at the common attitude towards sex. He found the talk of the barrack-room and the camp filled with nothing but woman and sex because it was the only talk which at once attracted his attention—he was unconsciously on the *qui vive* for every allusion to sex.

Those acquainted with the life among soldiers will know that sex-talk is no more rampant among them than among any other body of men. From an experience gained in three different campaigns with soldiers, British and non-British, in very different countries and under very different conditions, I have found the interests of the soldier as wide as life itself —at all events on active service where only I have been intimately associated with them and this most intimately, for a long sojourn in a besieged up-river

post produces the closest associations with one's fellow-sufferers. To one who has lived with men when they were doing the real fighting it is interesting to contrast the poetry written by warlike poets with that written by poet warriors.[3]

In our patient it was then this *fear* of sex that led him to try and put it on a rational basis. It was his own sexual problem that he must solve ; as is so frequently the case, his individual need became identified with the general need.

As type of his early adolescent phantasies the following may be given. He would imagine that his two schoolmistresses (much older than himself) were naked and he was driving them along whipping them, or he was bathing with them naked and striking them. Similar phantasies occurred with others, *e.g.*, with a little girl of his own age and with a typist engaged in an office with him. (Never had he phantasies with the ideal Miss X.) His *frank* discussions with women had never led him to the disclosure of these and similar phantasies that had haunted him for years.

A dream will show the nature of some of these phantasies.

On a boat running out of A— Harbour, going down the River B—.[4] *We went through a narrow passage which came gradually to a point, and got stuck in the mud. Ship did not stop. Looking out of the port hole window I saw a Zeppelin in the distance. It was attacked by a fleet of balloons. One burst and all the bits came dropping through the air.*

3 Compare Kipling's "Barrack Room Ballads" with the gallant Grenfell's "Into Battle" or the writings of journalists safe at home like Bottomley and Blatchford with the works of actual fighters like Boyd Cable and the author of "A Student in Arms."

4 I omit the names of these places to prevent identification of the patient.

One end of the Zeppelin was dropping but it rose and woke me up with a start.

The patient was totally unacquainted with psychoanalytic literature; he did not even know that he was being analysed; and, of course, no suggestion was made to him as to what might be the meaning of the dream. He was, however, well read in the Bible and other literature, so that with symbolic language he was at home. His associations to the incidents as described in the dream soon brought him to an appreciation of the symbols he had used. He discovered that the narrow passage stood for the vagina and that the mud was the anal region; that the boat coming down the passage (the vagina) was himself (*cf.*, the birth of Moses, of Ra, and other legendary heroes discovered in infancy floating in barks on water).

When by association he had identified the balloon as the womb and the Zeppelin as the phallus, and further associations showed that it was his mother's womb and his own phallus, the dream got a meaning for him. Birth is per anum or at least closely connected with that region of "filth." The sexual act is filthy like the act of defæcation; as another patient once put it to me, coitus was just the same as going to the w.c., to be performed on the same hygienic ground. His phallus (Zeppelin) is the prey of women (balloon) which will destroy his male power.

The further motive of the dream was then brought home to him. For him sexuality is a sin derived from the woman; "Through the woman came sin. The woman tempted me and I did eat." The meaning being that he would ascribe the blame for his difficulty in overcoming the adaptation to a normal life to the mother—this is the Œdipus *motiv*. Jung writes:[5] "The neurotic who cannot leave

5 "Psychology of the Unconscious." *Op. cit.*, p. 304.

the mother has good reasons ; the fear of death holds him. It seems as if no idea and no word were strong enough to express the meaning of this. Entire religions were constructed in order to give words to the immensity of this conflict. The struggle for expression which continued down through the centuries certainly cannot have its source in the restricted realm of the vulgar conception of incest. Rather one must understand the law which is ultimately expressed as incest prohibition, as coercion to domestication, and consider the religious systems as institutions which first receive, then organise and gradually sublimate, the motor forces of the animal nature not immediately available for cultural purposes."

With this dream we may take a later one.

"*With my mother in house in B. (town where he was born). We went for a walk and coming back I saw the house was on fire. Mother said, 'We've saved our wedding presents.' I asked if my books were saved, but they had all been burnt.*"

This dream requires some explanation. The patient in the anamesis had at first dilated upon the joy he had found in the marriage state: for the first time there had been complete harmony in his life. Analysis had shown that in reality the patient had been bitterly disappointed ; marriage was wholly distasteful and abhorrent. He had tried to overcome this repugnance and to make love become the rapture depicted by poets and novelists. He had thought that it was treachery to his bride to acknowledge even to himself his misgivings and vainly hoped with time the union would bring him, if not real happiness, at least contentment or that perhaps death in battle would solve the riddle.

What had rushed him into marriage did not become quite clear, but it is to be remembered that the army life gave him for a time certain satisfac-

tions (compare his phantasies), that at first he was able to forget himself and to become more normal. It was shortly after joining that he had his first amorous adventure; he took a young lady, whom he accidentally met, to some entertainment and went so far as to put his arm round her waist. There was a revulsion of feeling the next day but it was not long afterwards that he became engaged (not to this girl) and was married. He was perhaps carried away in this almost adolescent state by what Mr. H. G. Wells would call the enterprising female.

Now the patient understood that he was imperfectly developed, despite the rather wandering life he had led and the Army experiences; he knew himself to be quite immature and, like Peter Pan, he did not want to grow up.

Knowing that I could only treat the patient for a very short time, I did rather hurry him, but he was very intelligent and his unconscious in a receptive mood. He understood that relationship between his wife and himself would not be satisfactory until he swept away all dishonesties from himself, that the first step towards a real life in common was to do away with his pretended raptures and literary make-beliefs. Courage to face himself was the primary need. There followed 48 hours of acute misery—and then the dream—*his books were destroyed*—the mannerisms which were only plumes borrowed from others, were ended. Having divested himself of what was so merely external he must meet the world with his own resources. The dream suggests that there is in the unconscious no clear distinction between his wife and his mother; the house, his early home, like the city, is "a maternal symbol, a woman who fosters the inhabitants as children."[6]

6 Jung, *op. cit.*, p. 224.

Fire is a well-known symbol of passion, of the libido.[7]

The patient has gone a little way on the path to reality; he has discovered that his libido is still attached to his mother and that he must free himself therefrom before he can overcome his fear of sex. That fear overcome, he will be ready for the next stage in his development—sex will no longer fill the overwhelming rôle that it at present does in this masked fashion.

The process of self-deception must end if any harmony is to be established. We can understand that with this tremendous conflict of emotion raging within him the patient should be exhausted. There is inertia because the fight for reality loomed so terribly in front of him. There was no time to make a complete analysis, of course, nor to help the synthesis. It remains, as I said, a fragment, but the history suggests that sex must be on a satisfactory footing before the individual aim can be discovered or have any value. In some cases the understanding of the sexual life will be sufficient in itself to bring about a normal if somewhat restricted life.

IDIO-KINESIS.

No. 99. The patient is a married man, aged 29, a private of some months' service, who, after three months in France, was sent to Salonica, where he was invalided for severe and persistent backache, insomnia, and occasional enuresis. On Feb. 5th, 1916, he presented a widespread analgesia, with odd normal patches, and a zone of hyperæsthesia in the lumbar region. It is his mental condition, however, that will be here dealt with. There were sleeplessness, general restlessness, inability to fix his attention on anything for more than a few minutes.

7 Jung, *op. cit.*, p. 162, *et seq.*

In conversation with his mates he would, for instance, be suddenly quite oblivious of what they had been talking about and feel uncertain whether he had spoken or not. He read for a few lines and would throw down the paper. In writing home he once told me that he had begun twenty letters, destroying each, and then finished a few lines. He was so "shy" that he could only with difficulty walk along the hospital grounds, feeling then that everybody was looking at him. He had found it impossible to number off in the ranks, and had he to address his commanding officer he would become speechless. He was morbidly anxious about his family; though he had no reason to suspect illness, he would carry a letter from his wife two or three days in his pocket before venturing to open it, lest there should be bad news.

There were numerous obsessions or eccentricities. In walking he must mark each flagstone and touch each post. He had the impulse to count and to arrange things in patterns, counting on his fingers or the panes of windows in the rooms and arranging them in sets of twos, threes, etc. An obsession that came to light was an impossibility to go into a shop or restaurant alone. By dint of great effort he could thrust himself into a hosier's or tailor's shop alone, after a careful survey to ascertain that no other customers were present. This peculiarity was the cause of numerous embarrassments. His wife, to whom he was ashamed to confide the trouble, would ask him to buy something when he was going out. He would assent, realising at the same time the impossibility of the task, and already inventing some lame excuse to be presented on his return. Often had he gone without a meal when motoring alone because he could not face going into a restaurant.

At times a cloud seemed to come over him and he

did not seem in the world at all, but was without, a spectator watching and but dimly interested in the movements of men and women, himself included. He was a Public School man, with a well-developed and subtle intellect; he was well oriented in space and time. He realised quite well the absurdity of his obsessions, and, as he said to me, "I know I'm a damned fool and it's rot, but there it is, I cannot help myself."

We learn from his history:—That he had never done any work since he left school at 18 until he joined the Army as a private. He had substantial private means. He had been married three and a half years and had a son and was devotedly (morbidly?) attached to wife and child. His time had been engaged in travelling about the world, in various sports; he was an excellent shot and was selected for sniping in France, where his "bags" brought him great credit. He was the son of a well-to-do ship-builder and from the earliest days was passionately interested in ships and engineering. His school holidays were chiefly spent in his father's or the adjoining yards, where he was always planning, and later on designing, new kinds of ships and engines never to be used. During his boyhood's holidays he would accompany his father on business journeys and would sit in the customers' office whilst business transactions were carried on—always, in his own words, "gloating with joy at his father's cleverness and talk." From about six, or perhaps earlier, up till the age of eleven, he slept with his father in the same bed. He had a proper affection for his mother, but it was a pale reflection of the worship of his father.

He passed creditably through school, did quite well at games, and it was understood that he would enter his father's business. On leaving school his father

said : No need to hurry about business, take a couple of years and see the world. After two years he returned ready and anxious to enter business. But the father suddenly had a "nervous breakdown," and the son was compelled to remain in the closest attendance upon his father for the next year. The sick man would have no one else near him and would not listen to the youth's approaching the business. The father better, the son felt the real need of a change and went away for six months; he returned, and again there was the talk of his entering the business. His father had a second attack, and again for a whole year the son was chained to his father. He then again took some months rest, and on his return the father had withdrawn from the business; there was no longer talk of the son's doing anything. Indeed, any approach to the subject seemed so to agitate his father that his son, fearing another attack, avoided the subject.

This brief sketch will suffice to demonstrate the dominant part played by the father—the patient was assuredly the father's thing, no independent being. An incident will show this dependence. My patient was at a seaport when he was about 21, awaiting a ship to go abroad, when a friend of the family met him and invited him to stop there. He could give no reply, was extremely embarrassed, and wired to his father to come and help him. The father travelled the four hours' journey, and my patient only felt completely at ease when he met his father.

Now it is easy to see something unnatural in this relationship, to interpret it, following Freud, as a repressed homo-sexual father-complex, whilst the phobias could be explained as substitutes or derivatives of early repressed sexual curiosities; but this interpretation would be quite insufficient.

We learn that the boy passed through a normal

schooling, that no symptoms developed until the father's breakdown, that this breakdown was the frustration of the patient's whole ambition—to build ships and engines, to invent new kinds. That was his special work in life. He knew every important ship and most of the unimportant ones that were afloat. He could recognise a ship immediately; we often tested his knowledge, which never failed. He would recognise boats by their whistle and would at once say the particular ship's name, when she was built, her tonnage, etc. A fine ship passing the coast would fire him and rouse him from his lethargy. He experienced a sense of mystery and wonder in ships, something that Wordsworth must have felt when he wrote those sonnets:—

> "This ship was nought to me nor I to her,
> Yet I pursued her with a lover's look."
>
> " . . . and something dark
> Of the old sea, some reverential fear,
> Is with me at thy farewell, joyous bark."

He was in love with ships. Love of father, mother, to be a husband, etc., these he shared with humanity in common—but ships—that was the individual thing which absorbed such energies as were not to be devoted to the common duties of life. His father stood to him for power and ships and engines—through the father he could climb to his own pinnacle. And then comes failure. The patient, inhibited from following his purpose, regresses, turns back and seeks in his phantasies the consolations and the position which belong quite legitimately to childhood but do not fill up the adult outlook.

If we have hitherto written of the unconscious as something archaic and crude, we must now correct that by adding that the unconscious is also creative and constructive. A cross-section, so to say, of any mind at any given moment would reveal not only the

past but the germs of the future—the potentialities to become realities with time. The psyche never is, but is always becoming—changing; there is ever an onward thrust.

Biologically the great functions of life are:—

I. Those directed to the individual comprising (*a*) Self-conservation and (*b*) Growth.

II. Those directed to the species comprising (*a*) Preservation of the race and (*b*) Racial development (variations).

But we discover in human beings a spiritual life apart from and independent of the biological principle. This has also two relationships. It is related to the universal spirit as part of the world-consciousness and it is related to the self, forming the individual spiritual life. This desire for an increasing individual life of the spirit is a strong dynamic force which we may call idio-kinesis. This idio-kinesis does not, among ordinary normal persons (I must exclude certain individuals, *e.g.*, the true saints), demand full expression until the biological energy of the individual has received or is receiving its due satisfaction. Conflict ensues—a neurosis—when the ordinary individual endeavours to satisfy his spiritual life without having satisfied his biological functions; again, neurosis may arise from a thwarting of the spiritual life by conflict between the energy directed towards the world-consciousness and the idio-kinesis. Again, since this latter is ever undergoing change, we have here a constant source of conflict within the self. Idio-kinesis finds its expression in the most diverse ways. In this patient it was seeking expression in ships; conflict had produced stagnation. The energy which should have found individual expression [this idio-kinesis] was stayed. Hence his suffering. He could marry and fulfil some common biological objectives of life. The difficulties were enormous—

granted, but life is relentless. Difficulties must be surmounted. And the patient was gradually learning this.

Two of his latest dreams illustrate this new adaptation.

"*I was in a cargo boat in the river; we were steering straight into the ferry and harbour. The pilot rang down full speed astern. I pushed him out of the way and rang down full speed ahead, two points to starboard. We went straight past ferry and harbour without an accident.*"

A few days later :—

"*In a motor car : came to some rocks which sprang up in front of me. The machine broke down. I abandoned it and walked, clambering over the rocks. It was tough work. My object was a ship. I got to the ship ; took hold of the wrench and signalled to let go.*"

We found by analysis that the pilot in the first dream and the motor in the second stood for the father. The meaning became clear. He must first sacrifice (knock down, abandon) the father element in himself, then his life's purpose (ship), will be directed ahead and in the right way (starboard). There are difficulties (rocks) ahead, but he will climb over them. When the unconscious of our patient has reached this, when he has thoroughly learnt that he must surrender that which is infantile and immature in himself—the clinging to the father—that he must be master of himself, we have reached a new view-point. All his will-power will be still required to make good the lesson but he need no longer be the victim of unknown impulses. He is not cured, but he has begun to see in what direction the world might again live for him when his energy began to be directed in these new channels ; the phobias and obsessions, even those unanalysed, began to diminish in strength.

But until these had been fully analysed he would be wanting in the knowledge required to secure the fullness of a new attitude towards life—there would be continual backslidings—regressions.

The time at our disposal was too short to do more than get him to catch a glimpse of the promised land. He has yet to climb his Mount Pisgah to obtain a full vision.

It will be seen that in these cases of psychasthenia no cures were effected; the patients could not remain long enough under treatment for this; a cure in these bad cases requires months. We had to be satisfied when the acute psychical symptoms abated. These were all cases of pre-war neurosis on a psychopathic basis —the cases that remain more or less invalids—with ever recurrent breakdowns, ending perhaps finally in an asylum. If such illnesses are taken seriously as soon as the symptoms show themselves, psychoanalysis offers them good hope, I believe the only hope, of fulfilling themselves, of averting the otherwise almost certain uselessness of their lives and the too frequent miserable termination. But these considerations do not properly belong to a book on war-shock.

DREAMS.

Dreams play so large a part in the diagnosis of the psycho-neuroses that I must add a few words on the subject, though it is one too large to treat in this little book; fortunately there is now an available literature.[8]

8 "The Interpretation of Dreams," by Prof. Sigm. Freud. Translated by Dr. A. A. Brill. London: Allen & Unwin. 1913.
"On Dreams," by S. Freud. Translated by Dr. M. D. Eder. London: William Heinemann. 1913.
Freud's "Theory of Dreams," by Dr. Ernest Jones. *op. cit.*
"Analytical Psychology," by C. J. Jung, *op. cit.*

Naturally a good deal of fun has been made of dream-analysis, which is likened to the dream interpretation of the ancients. With this it has as much resemblance as has modern urinary analysis to the water casting of the Middle Ages. The water casters felt that such an excretion as the urine must be of some use in the diagnosis of disease and they made guesses, sometimes true guesses, at discovering what the changes in the urine, changes in colour and so on, could possibly signify. It was left for a later age to invent a technique for the examination of the urine and thereby to interpret its changes in various diseases. Similarly with dreams, our predecessors felt that dreams must have some message, and they made guesses, sometimes correct, at what the message could be; but it was left to Sigmund Freud to discover a scientific technique whereby to read the riddle of the dream. Of course many acute minds had before Freud dimly felt that in some way the dream might be significant. Bagehot[9] has a rather remarkable passage which is worth quoting. Writing in 1871, he says :—

"That belief is not a purely intellectual matter is evident from dreams, when we are always believing, but scarcely ever arguing ; and from certain forms of insanity, when fixed delusions seize upon the mind and generate a firmer belief than any sane person is capable of. These are, of course, 'unorthodox' states of mind, but a good psychology must explain them, nevertheless, and perhaps it would have progressed faster if it had been more ready to compare them with the waking states of sane people."

As an introduction to the understanding of dreams, we may recall the varieties of symbolic conversion in Chapter III. In the functional paralysis

9 "On the Emotion of Conviction," by Walter Bagehot. Vol. III., p. 192, of his collected Literary Studies.

of the hysteric one finds ideas, wishes and mental processes in general represented by their physical counterparts. So it is in dreams. The pictures in the dreams stand for, are symbols of, mental processes. We find an instance of a horse being the symbol of the man himself (p. 81), of fire symbolising passion, inability to move standing for indecision of the mind, and so on.

It must be remembered that in dream-analysis the symbols to be interpreted are individual, not only to the person, but may even be to the dream itself. Thus, fire may not symbolize the same idea to another person as it did to No. 100. In the dream of No. 78, and at subsequent stages of the analysis of the same person, it might be found that fire had another symbolic value.

The discussion of typical symbols would take us too far, and would lead into the regions of folk-lore, comparative religion and mythology. Those interested should read Jung's "Psychology of the Unconscious"[1] where, taking the published phantasies of a modern young lady he has sought to unravel them by a comparison with the symbolisms of mythology and religion.

The value of the dream is that it gives us, in disguised form, something direct from the unconscious. One word of warning is necessary; the meaning of the dream is only to be apprehended from its latent content—that is to say, when all the "free associations" to the component parts of the dream have been given. From the dream, as dreamt and related, *the manifest content*, no meaning is to be deduced.

It is to be remembered that there are two motives for the symbolisation and the endopsychic censure is different in the two cases. Firstly, to conceal the

1 "The Psychology of the Unconscious." Translated by Dr. B. M. Hinkle. New York: Moffat, Yard & Co. 1916.

dream thoughts from the dreamer's conscious self, the censor prevents ideas out of harmony with the dreamer's conscious self, a more highly developed self, from entering into consciousness. Secondly, to prevent the apprehension of an idea which is beyond the dreamer's experience. In the first case the meaning of the symbols used may be apparent to the outsider though not to the dreamer, since the main object is a self-concealment, whilst the attempt to prevent others knowing the dream thought is only secondary. In the second case only the dreamer himself can really furnish the clues to his symbols; though it has an apparent rendering in universal terms it has a quite particular application. The dream here deals with the future and present, using the past experiences because they are the only means of comparison which the dreamer has. The motor-car dream (p. 113) is such a dream, showing what Jung calls the *prospective tendency* of the unconscious.

CHAPTER VI

DIAGNOSIS

THE soldier is not immune from the nervous diseases of the civilian; syphilis of the central nervous system is found among men in the fighting line, as are tumours of that system, disseminated sclerosis, epilepsy and so on. The diagnosis among soldiers of these diseases from the psycho-neuroses does not present any new features.

The differential diagnosis of epileptic from hysterical fits is of medico-military importance and at times difficult; we may not see the soldier in a fit and may have to rely upon the description of the attack given by himself or his comrades. There is hardly any feature in the epileptic attack which may not occur in a hysterical attack; biting the tongue, the emptying of the bladder or of the rectum may be present in hysteria. In the chronic epileptic, an unlikely person to be found at the front, the well-known stigmata of the epileptic character, such as limitation of the field of presentation, retardation of all response to stimuli, stereotypy and poverty of speech, moodiness, egocentricity, exuberant emotion, irritability, suffice to make the diagnosis easy.

The question of epileptic or hysterical fits may be sometimes settled by a psycho-analytic diagnosis. The word-association test, which Ernest Jones[1] has

1 *Op. cit.*, p. 210.

likened to the differential blood count, may be often useful in this examination. Reliance is not to be placed so much upon critical words as upon the interpretation of the results. The experiment is very easily carried out, but this interpretation, like that of every other psychological test, requires judgment and experience. Jung[2] gives the following reactions as characteristic of epileptics:—

(*a*) Explanations of an extremely awkward and detached character are given by way of confirmation and completion of the reactions. The stimulus-word is frequently repeated in the reaction.

(*b*) The outer form of the reaction is neither stereotyped nor limited except in regard to its *egocentric* formation, which occurs with peculiar frequency (31 per cent.).

(*c*) The emotional references are frequent, they are almost undisguised (religion, moralising, etc).

(*d*) The reaction-times show their most extreme variations only after the critical reactions. The abnormally delayed times are not found at peculiarly difficult words but at places which are determined by the preservation of an emotional tone.

In the following case the diagnosis of hysteria was made on the result of a word-test (200 words), which disclosed nothing characteristic of epilepsy, and by the fortunate chance that two recent dreams were remembered and at our disposal.

No. 75, a garrison soldier, aged 21, felt giddy whilst sitting on a wheelbarrow, screamed out and fell to the ground in a fit. He felt sick afterwards but did not vomit. Two days later he passed his

2 "Studies in Word-Association." *Op. cit.* Chapter III. "Analysis of the Associations of an Epileptic," by C. G. Jung.

water whilst sleeping on his bed in the afternoon; he awoke with a violent headache. Later that evening whilst standing he had another "fit" and fell. He did not pass water but awoke with a burning head. He was carried to his bed by some of his companions. He had not hurt himself in the fall. There was no injury to the tongue. A witness who had inserted a wedge into the patient's mouth, but whose evidence of the attack was confused and unreliable, said there was blood-stained froth at the mouth. The patient stated that he had had "fainting fits" between the ages of 9 and 15; in one fit he is said to have bitten his tongue; he had been excused school-attendance on account of these fits. He remembered wetting the bed sometimes up to his eighth or ninth year. The patient was admitted to hospital, and I saw him the day after the second attack when he still complained of headache.

He was a driver engaged in garrison duty; the day after the first fit he was afraid to take out the horses; he had a vision: "the horses falling on the hill and the waggon running into them." He had not previously suffered from fears of any kind. He took the horses out but with great qualms; there was no accident. The night before the first fit he had a dream: "*Our stables had been turned into a big hospital where I was.*"

The night before the second fit (*i.e.*, after having taken out the horses) he dreamt: "*That the stable was built differently; that it was now the ward of a hospital; we had 18 men there: I saw all the beds in the stables, and I was lying in one of the beds with clean sheets.*"

Analysis: There are only four men now in the detachment, which means that each man has to be on guard every other night in addition to the day duties. (Guard from 6 p.m. to midnight, or midnight to 6 a.m.)

He has felt the want of sleep through the many guards he has to do. One of his chums has had appendix trouble and has been sent home; another is in hospital with enteric fever. Just before the fit he had been boasting that he was the only one who had never been ill. He had been in M—— 15 months; he liked it at first, but the routine work has become very dull, and he has nothing to do in his spare time. He would like to get to the front, but there was no chance; thought he deserved a change and to be sent home. He was engaged before he left, but he heard recently that the young lady had broken off the engagement.

Both dreams express the same unconscious wish-fulfilment. He will never get away from M—— unless he is ill; the stables are thus conveniently turned into a hospital ward and he is in hospital. One chum has already gone home and the other is going (all enterics being ultimately sent to England). *Boasting* about something is a not uncommon form of an unconscious wish for the opposite. The fear about an accident with the horses is a (repressed) wish not to have the horses to take out. Meantime he conscientiously carries on his work. The conflict between the conscious and unconscious trends ends in the hysterical attack with fulfilment of the unconscious wish—for he is ill and sent into hospital.

The analysis was not pursued further, so that the meaning of the childhood's fainting attacks cannot be given. It is significant that he was a "bed wetter" till rather late in childhood; the emptying of the bladder after the first fit is probably connected with the renewal of certain childhood's conflicts. The results of the analysis of the dreams undertaken entirely for diagnosis, not for therapeutic purposes, were of course not communicated to the patient.

In the diagnosis of functional disease, even where

it seems self-evident, complete and systematic examination is of course to be made. The presence of organic affections, in addition to the functional one, may be revealed, or some further stigmata may be discovered. An interesting observation of the former condition is described by Purves Stewart[3] in a soldier with wrist-drop of the left hand due to a shrapnel bullet, whose track had crossed the musculo-spiral groove. There was, however, complete anæsthesia of the left upper limb from the acromion downwards ; an anæsthesia, therefore, not corresponding with the distribution of the injured nerve.

In mutism and deafness the symptoms seem obvious, but without systematic examination malingering is not excluded and the analgesia sometimes co-existing with mutism and deafness, such as described on p. 37, would be missed. In mutism the patient should be examined to see whether he can whistle, laugh, cough, sigh; mutism is sometimes complete; a good test for the cough is to strip him as for examination of a hernia, asking the patient to cough ; this routine examination, which all soldiers have gone through, may take him off his guard. The patients can express themselves well in writing, unlike ordinary aphasics. The laryngoscope may show adductor paralysis. The faradic current should not be used in hysterical mutism of soldiers, useful though it is in the common functional aphonia of girls and others. In functional deafness and amblyopia the services of the specialist, if available, should be requisitioned to make a report upon the state of the special senses—not necessarily a diagnosis of the patient's condition.[4] An older generation of clinicians

3 *Op. cit.* (4th Edition), p. 61.

4 In Malta I was fortunate enough to have the opinion of Col. Purves Stewart, A.M.S., for most of the general cases, and of Capt. A. D. Griffith, R.A.M.C., as well for the eye cases.

called these amblyopias anæsthesia of the retina; it is not a bad term as a clinical description, although the stimuli are really conveyed to the brain, just as they are in anæsthesia of the skin. The ophthalmoscopic examination is negative; the patient is not betrayed by any of the tests which reveal the malingerer. Convergence may be absent and the examination of the visual fields may show the characteristic stigmata of hysteria. There is a concentric contraction of the visual field (see pp. 34, 35) with alterations in the colour fields.

The examination of hysterical paralysis shows:—

(1) The anæsthesia corresponds to no anatomical nerve-distribution. It is regional, not anatomical, in its distribution. As we have seen in Chapter II, a complete hemianalgesia is common, and this, unless there be special cause to the contrary, is on the left side in right-handed people and *vice versa*.

Sometimes the patient, though he says he is unable to feel a pin-prick, can locate it on or near to the place pricked with the normal hand. The joint sense may be impaired and astereognosis be present with this anæsthesia; the yes-no test is sometimes positive. That is, the patient answers "no" when pricked in the anæsthetic area without noticing the contradiction, when asked to say "yes" when he feels the prick, "no" when he does not feel it.

(2) As recovery sets in the anæsthesia fades away gradually towards the periphery;[5] one can sometimes, mark its progress from day to day, or sometimes under suggestion, it disappears with absolute suddenness. Thus, to a soldier with a complete left hemianalgesia of unknown duration it was suggested under hypnosis that he could now feel the prick of the pin on his arm, and he did. It was then said: "You can feel everything all over the body." Sensation

5 See the illustrations in Purves Stewart, *op. cit.*, p. 394-5.

became at once normal and so remained after he was awake.

(3) There may be impairment of joint sense and astereognosis due to the anæsthesia.

(4) The gait is often typical in hysterical paraplegics; thepatient *shuffling along*, sometimes supporting himself and falling rather softly if all support is taken away.

(5) The reflexes may be sometimes exaggerated in functional as they often are in organic diseases, but they are never absent permanently in functional disease.

(6) The paralysis, like the anæsthesia, follows, as a rule, no anatomical rule; movements as a whole are affected.

(7) The muscles respond to faradism in hysterical palsies; reaction of degeneration is absent.

The use of finger prints has been suggested in the diagnosis of functional from organic diseases of the upper limbs. It is said that when the finger prints of the two hands are compared there will be found an alteration in the finger prints of the injured side in injuries, more especially, of the median and ulnar nerves, whilst no changes are found, or but rarely, in functional disease.[6]

The diagnosis of the psycho-neuroses must not be allowed to rest upon negative evidence; it does not suffice to diagnose a hysterical paralysis by a process of exclusion. Positive evidence must be obtained by a psychological examination which should, at the same time, discover the mechanism and pathology of the symptoms.

MALINGERING.

To confuse functional disease, war-shock, with malingering is no more excusable than would be the mistaking of an innocent tumour for a malignant

6 Cestan, Descomps and Euzière. La Presse Médicale, 1916, June 8, p. 261.

tumour. We are all, physicians and surgeons, liable to error, but though the sufferers may pardon our mistakes and we may excuse them in others, we must never condone our own mistakes in diagnosis.

The differentiation between a psycho-neurosis and malingering is, in principle, psychological. In malingering the motive is conscious, the patient consciously pretends to suffer from some symptom; in functional disease the motive is unconscious; the symptom develops in obedience to motives, desires, causes, of which the patient's consciousness knows nothing.

Simple cases of malingering are recognised by simple psychological observation; one infers at once from the patient's general demeanour, from his story and so on, that he is shamming. More refined malingering, especially where there has been some original trauma, requires more complete physical and psychical examination. In this, as in every other branch of medicine, reliance should not be made upon some "infallible" test, say the electric battery applied to the seat of pain, but upon a balancing of many signs and symptoms and the observer should try to keep himself as unbiassed as possible. A good beginning is for the observer to remember that he is biassed in one direction or other, and to try and discover, if possible, his particular bias. My own experience in the army has been almost entirely amid the sick and wounded; among these patients I can confirm the statements of Myers[7] and others that malingering is most rare. The regimental M.O. may, of course, have a different story to tell. A complete physical examination of every patient, even when malingering is strongly suspected, is the first important step in diagnosis. (This remark does not apply so rigidly to the regimental doctor to whom the idiosyncrasies of the men will be known.) Disturbances of

7 *Loc. cit.*, p. 608.

sensation, the peculiarity of gait, are important; the malingerer's gait, however skilful, does not correspond to the peculiar shuffle of the hysteric. All text-books on eye-diseases give tests for pretended blindness.

In hysterical deafness the patient has often the "woolly" appearance of the organically deaf, which the shammer does not show. The beginning of a reply to a question by movements of the larynx, lips and mouth will be often noticed in the shammer, who will, on cross-examination, indignantly deny having made them; the hysterical patient's attitude is very different, to him it is not an accusation.

Dundas Grant[8] points out that patients with psychical deafness sometimes acquire lip-reading with great rapidity, which he regards as "unquestionable evidence of a high degree of deafness." Grant suggests the following test:

"It is the dilatation of the pupil which follows the sudden blowing of a whistle without the patient being aware of it; in several cases of labyrinthine deafness this was absent, but in others which seemed to be of psychical origin the reflex was present, although the deafness was absolute or nearly so. In the dullness of hearing due to exhaustion, which shows the tuning-fork indications of nerve-deafness, there is usually preservation of hearing for the highest pitched tones. Labyrinthine and psychical deafness may be combined, but the labyrinthine factor is generally unilateral."

"Exaggeration" of symptoms or undue sensibility to pain is not malingering; one man with a functional paraplegia will be cheerful and try his utmost to get about; another with the same affection will be depressed, complain that he is done for life, cannot

8 Discussion on Shell-shock. Proceedings of Royal Society Medicine, *loc. cit.*, p. xxxviii.

walk a step. These are temperamental differences which we all allow for in organic diseases and must be prepared to find in functional diseases likewise. A patient's desire to make the most of a symptom neither excludes functional nor organic disease.

Functional disease may exist along with malingering, just as we have seen that organic and functional disease are not mutually exclusive.

In all serious cases a psychological examination should be made. The discovery of the unconscious motive for the symptom, its psychological explanation, diagnoses the condition. Though psychotherapy is not admissible as a therapeutic test, the cure of the symptom by psychotherapeutic measures will confirm the diagnosis arrived at before treatment.

The differential diagnosis of the psycho-neuroses from one another is based upon the psychological principles set forth in the earlier chapters.

CHAPTER VII

TREATMENT

THE results of psychotherapy in cases of war-shock establish its claim to be the chief method of treatment. The following table summarises the results in the first hundred unselected cases treated:—

Method of Treatment.	Cured.	Improved.	No change.	Total.
Suggestion under hypnotism ...	70	7	2	79
Suggestion without hypnotism	3	2	—	5
Suggestion under anæsthetic ...	6	—	—	6
Psycho-analysis...	1	4	—	5
Other methods ...	—	1	1	2
Diagnosis without treatment	—	—	[3]	3
	80	14	6 [3]	100

By a cure we mean complete cessation of all the symptoms; a certain number of these patients when cured were sent into the convalescent camps at Malta and were then drafted back to the Front. The majority went back to England at varying intervals after their recovery, the intervals varying with the military-medical requirements. I often tried to ascertain the subsequent fortunes of these patients, but have only succeeded in a few instances.

By improvement is meant relief of some symptoms only; thus, the paraplegic, No. 9, was able to walk

normally, the analgesia had gone, but as the rigidity of the back remained when he left us we had not reckoned it a cure. (A wider claim for this particular case is made by Purves Stewart,[1] who writes, "under treatment by suggestion the weakness of the legs rapidly disappeared, the 'stocking' anæsthesia cleared up and the patient became able to walk normally.")

In the cases where the prominent symptoms are psychical we have reckoned it an improvement when sleep returned, the patient could control himself and concentrate his attention.

The cure in the great majority of cases took place very rapidly; *e.g.*, mutism recovered in the course of a few minutes; many cases of palsy or complete paralysis (hemiplegia) recovered in less than 24 hours. Cases frequently called neurasthenia, but which I have here included among the anxiety-neuroses, were the slowest in recovering, but in many of these cases the main symptoms, such as the exhaustion, insomnia, dread, headache, tremors, disappeared in a week. No case was under treatment for more than four weeks; very few remained under treatment for more than two weeks.

Of secondary importance is treatment by what Dr. Stansfield calls "rational lines,"[2]—"absolute rest and quietness, with all the sleep possible, preferably with agreeable surroundings in the country; a nourishing, easily assimilated food, and the like," or by what Major Mott[3] denotes as "only common sense and interest in the welfare and amusement of these neurotic patients."

Hydrotherapy, electrotherapy, massage are, in

1 *Loc. cit.*, p. 516.
2 Proceedings of Royal Society. Discussion on Shell-shock *Loc. cit.*, p. 32.
3 *The Lancet*, March 11th, 1916., p. 553.

my opinion, of tertiary importance; I agree with Dr. Leonard Guthrie,[4] who says, "I believe that all forms of treatment involve the employment of either suggestion and persuasion or of some novel and unexpected emotional or physical shock," with the exception of treatment by psycho-analysis, which does not involve anything of this kind.

We, of course, want the best surroundings we can get for our patients, just as the surgeon would desire them in the case of a fractured bone but, just as he employs something specific to the bone injury, so we should employ something specific to the mental injury.

"Rational lines of treatment," "common-sense," demand the treatment which most rapidly relieves the patient and sends him back to the army most quickly.

Suggestion under hypnotism, especially when the suggestions are based on the knowledge of the particular psychological mechanism which has produced the symptom, is, from this rational point of view, the method of election for cases of *war-shock* in the soldier.

The soldier is peculiarly susceptible to suggestion; the whole training and discipline make him respond to the authority of the Medical Officer.

It is because war-shock differs in the respects already pointed out from the psycho-neuroses such as we see in civilian practice, and of which the war also furnishes instances—I have discussed several cases in this book—that the results of suggestion are so much more favourable than are usually obtained, at any rate in my own knowledge, in civil practice.

Babinski[5] distinguishes functional cases that disappear rapidly under psychotherapy from those in

4 Proceedings, Royal Society, *loc. cit.*, p. 41.
5 Revue Neurologique, 1916. Nos. 4—5, p. 52.

whom this method seems to have no effect. His view is endorsed by Grasset, Claude, and others. A better division is into the following group:—

A. War-shock; cases of psycho-neurosis without previous history, family or personal.
B. Non war-shock; psycho-neurosis with a previous history.

There were, as already stated, in the one hundred cases, 70 of Group A. and 30 of Group B.

The following table shows the comparative results of the treatment of the two groups; both total cases and in percentages:—

RESULT OF TREATMENT OF 100 CASES.

	War-shock.		Non War-shock.	
Cured ...	62	91·5 per cent.	18	62 per cent.
Improved ...	6	8·5 ,,	8	27·6 ,,
No change ...	—	—	3	10·4 ,,
No treatment. diagnosis only	2	—	1	
	70	100	30	100

Of the war-shock cases 68 were treated, and of the non war-shock, 29. As might be expected the former give better results, 91·5 per cent : 62 per cent.

In no case of the former was the condition unchanged, all three total failures (10·4 per cent.) being among the non war-shock cases. No results of any value are obtained by a comparison of the results obtained by the different methods of psychotherapy that were employed. For instance, all the cases treated by suggestion under an anæsthetic were cured, but this method was selected for the deaf and dumb cases in whom there were obvious difficulties in the way of hypnotising. It can be done by writing, but it is a tedious process unless one has an exceptionally clear and imposing script.

Again, only one case out of five was cured by

psycho-analysis but this method was only applied in non war-shock cases of great severity with a strong neuropathic history (family and personal).

The particular psychotherapeutic method employed was selected as the most appropriate after the preliminary psychological and clinical examination.

The objection raised to treatment by suggestion under hypnosis, *e.g.*, by Dejerine and Gauckler,[6] that one weakens instead of strengthening the patient's critical powers, applies, as I pointed out in my Malta Address (*loc. cit.*, p. 668), and as Professor Elliot Smith also observes[7] to suggestion in all forms, whether it takes the form of suggestion in the waking state, common-sense talks, rest, distraction, electrotherapy, or spontaneous recovery.

The objection has no validity in cases of war-shock, though it has point in cases of profound hysteria or psychasthenia which come under notice in civil life.

Minor advantages of psychotherapy are that it requires no elaborate apparatus, no prolonged sojourn in hospital, and has no savour of charlatanism like the more popular and less efficient methods such as electrotherapy, massage, Weir-Mitchell treatment.

By none of these methods, not even in spontaneous recovery, does the patient learn, although he may obtain intellectual apprehension, the real significance of his illness, nor can this be brought home by any arguments addressed to the conscious self (such as Dubois' persuasion method).

Psycho-analysis, which was employed in six cases of the 100 (in one case for diagnosis only) is the only method that enables the patient to deal with the underlying mental state, and not merely with the symptom; in psycho-analysis the patient learns for

6 "Les maladies fonctionelles des Psychonevroses." Paris: Masson & Co., 1911.

7 *Loc. cit.*, p. 27.

himself the real significance of his disease, a privilege only acquired by a bitter self-realisation.

Whilst it is, in my opinion, the only method for the radical treatment of the psycho-neuroses, it is inapplicable and unnecessary for the treatment of cases of war-shock, and for many of the psycho-neuroses occurring among soldiers. To use it here is to employ a Nasmyth hammer to crack a nut.

The shock of battle is not an every-day affair—especially such warfare as this. It is this unusual experience, so utterly foreign to the normal routine of life, that has bowled the man out. He requires temporary reinforcement of his own will-power, and this is just what hypnotic suggestion supplies.

The practical objection, apart from the philosophical objection, in the ordinary civilian type of psycho-neurosis that one symptom is cured to be replaced by some other symptom, does not hold in war-shock cases, the symptoms when cured are not, in my experience, replaced by other symptoms.

The results obtained in Malta may claim to be due purely to psychotherapy. The patients were two thousand miles from Britain and did not know whether they would be sent home or back to the Front on recovery. No bribe was offered in the shape of a promise to get the patient sent to England on recovery; many cases, indeed, owing to the military-medical situation, had to be sent to the Convalescent Camps and so back to the Front on recovery, and this sooner than was altogether advisable.

Babinski[8] and other French authorities have recognised the value of psychotherapy in the treatment of the war psycho-neuroses. Nonne[9] also speaks

8 *Loc. cit.*

9 Nonne. Zur therapeutischen Verwendung der Hypnose bei Fällen von Kriegshysterie. Med. Klinik, 1915, p. 51/52.

of the exceptionally good effect of systematic and exclusive hypnosis in these cases. Out of 63 of his cases 51 were cured, 46 by suggestion under hypnosis, 5 by suggestion in the waking state; of the 12 cases uncured 10 were refractory to hypnotism. (A very large number which leads me to believe that these were not cases of war-shock as defined in this book.)

GENERAL PROCEDURE.

It may be well to state exactly what the procedure was.

The patients were transferred to the psycho-neurological department, after having been seen by one of the consulting physicians to the Malta Command and recommended for treatment. A few cases from neighbouring hospitals were treated as out-patients, of course with the sanction of the C.O.

These patients when admitted were scattered in the various wards, so as to avoid a conglomeration of persons suffering from nerves with, it was feared, disastrous intercommunication.

But this is not necessary or desirable. The patients could not be prevented meeting and talking with one another in the grounds or wards, etc.; indeed, it was not a case of evil communications corrupting good manners, the contrary was the case. The new patients were able to note the rapid progress towards recovery of the older ones.

The patient underwent a physical examination in the ward after admission. He then came to a "bunk" placed at my disposal by the O.C. (Lt.-Col. Scanlon). This was a bare, whitewashed room furnished with an armchair, "officer's table" and wooden chair. The psychological investigation was conducted in private. No one was allowed into the room. The patient was comfortably seated in the chair and put as much at ease as possible. An ex-

planation was given to him as to the nature of the proposed enquiry and treatment, and he was encouraged to talk about himself and his illness, his life in the army, and so on; any dreams were taken, but nothing more was done the first day. The next day, after a short conversation, when the procedure of hypnotism was explained, hypnotism was induced, and suggestions given based when possible on the results of the psychological observation. In most cases Liébault's method of inducing hypnotism by direct suggestion readily produced drowsiness. Sometimes Braid's method was adopted at the first attempt, an ophthalmoscopic mirror being held before the patient's eyes for a few minutes.

As a rule the stage of drowsiness was quite sufficient for our purposes; but when further insight was desired on the pathological aspects of the disease, and sometimes for treatment, deep sleep and somnambulism were produced.

In producing hypnosis there was no necessity to exclude the presence of strangers and the sitting was used as a means of demonstrating the production and phenomena of hypnotism to one's colleagues.

Collective suggestion under hypnotism was found also of practical value. We could have four or five patients on ordinary chairs (the room not holding more comfortably), and hypnotise them all (either singly or collectively), passing from one to another with the individual suggestions.

This saved time and allowed more time for the individual examinations. As a rule a patient was not kept under hypnosis longer than fifteen or twenty minutes. After being awakened, he was required to carry out consciously what he had accomplished under hypnosis and was then directed to return to his ward and rest for half an hour.

A too long prolonged hypnotism is exhausting to most persons and retards recovery.

The patients were seen every day alone; naturally with 20 to 30 patients one could not give an hour to each daily ; for some, 10 minutes had to suffice when one perhaps gathered some fresh information or obtained a dream.

Hypnotism is easily induced among soldiers ; in only three cases of them did it altogether fail at the first attempt.

The selection of cases unsuitable for this procedure was made after the psychological examination.

If, after a few days treatment, no improvement was noticed, hypnotism was given up and suggestion in the waking state was tried.

HYPNOTISM UNDER ANÆSTHETIC.

On June 10th, 1915, a deaf mute, No. 35, was admitted into my ward from Gallipoli, the only medical case in a batch of wounded soldiers. The work was very heavy, the hospital having been opened on the 8th of June, and I wrote to the patient I would attend to him in a day or two, and he would get well. It was not till three days later that we could take him in hand; enquiries were made in writing ; this was found a tedious business (my handwriting, I regret to say, is none too good), and hypnosis under such conditions did not promise to be very satisfactory, so recourse was had to the well-known method of inducing hypnotism under an anæsthetic.

This method of inducing hypnotism under an anæsthetic should be reserved for cases where hypnosis is very difficult ; personally I should restrict it to functional deaf mutism, mutism, or deafness.

Milligan[1] advocates this method not only in those cases but also in hysterical loss of memory, palsies, deformities. Hypnosis is so readily induced among soldiers that there is no reason at all for submitting these patients to the extra risk of an anæsthetic. Suggestion under ordinary hypnosis works quite as rapidly as when under an anæsthetic.

Chloroform was given till light anæsthesia was obtained; the patient was then told he would be able to hear and speak when he woke up. A mouth-gag and the tongue-forceps were used. The suggestion was repeated continuously until the patient awoke. The patient spoke whilst under the anæsthetic. A gramophone happened to be playing in the adjoining ward; this was the first sound he heard on awaking; the goat-bells outside were next heard. He spoke a little later. This method was used in all cases of deaf mutism with entire success. It failed in one case under the care of Lt. Fothergill, R.A.M.C. This patient had been previously hypnotised by Lt. Fothergill but the suggestion had not been successful.

In another case of mutism, No. 42, hypnotism was induced, but the suggestion was unsuccessful. The chloroform method was not used because the patient, on the advice of a doctor, did not wish it. This patient had been rather harshly treated. It would seem that a surgeon who saw him was inclined to regard it as a case of malingering, and applied the electric battery to the larynx, which made him feel worse; the battery was used a second time; perhaps, rather naturally, the surgeon somewhat resented the failure of the patient to improve under a mode of treatment which had been often successful in hysterical aphonia among girls. The patient came under me some ten

1 "A Method of Treatment of Shell-shock," by E. T. C. Milligan, M.D., B.S. *The British Medical Journal*, July 15th, 1916, p. 73.

weeks after he had been on the island; suggestion under hypnosis failed, but I began in the conscious state the re-education of his speech. One by one, I got him to pronounce the letters of the alphabet, by showing him the position for each letter; he was getting successful with simple consonants and words when he had to be transferred to England.

PHYSIOLOGICAL RE-EDUCATION.

This process (physiological re-education) is, of course, slow, but in cases of long standing when other therapy fails it deserves consideration.

Re-education is a method to fall back upon in cases of paralysis when psychotherapeutic methods fail. Each part of the limb must be separately educated to fulfil its function, and finally co-ordination of the limbs and body must be taught.

This method of physiological re-education is also recommended by Briand and Philippe[2] in obstinate cases, who cite a case of deaf mutism of some duration successfully treated by exercises in respiration, blowing, whistling and phonation.

SUGGESTION WITHOUT HYPNOSIS.

Treatment by suggestion without hypnosis is of course familiar to every practitioner; the patient is encouraged by being assured that there is no physical injury, that he will get better, that it depends on his own good will. But it is not everybody who can be thus helped to make an effort; it is desirable to adapt the language to the patient. There are some persons who resent talk of this nature and on whom it would have the contrary effect. A certain tact is required to discover this and to fit the exhortation

2 "L'audi-mutité rebelle d'origine émotionelle." Le Progrès Médicale: September 5th, 1916, p. 147.

to the patient. Just as we must adapt the splint to the individual fractured limb, so we must adapt our suggestion to the individual paralysed mind; stock suggestions are no better than stock splints for injured soldiers.

PERSUASION—RE-EDUCATION.

These are terms given by various writers to suggestion without hypnosis. Dejerine and Gauckler[3] say that "it consists in explaining to the patient the true reasons for his condition. The part that the physician plays is to recall, awaken and direct."

To the patient this comes merely as suggestion; cure comes about, although the writers have failed to recognise it, exactly in the same way as by suggestion under hypnosis, that is, by "transference" to the physician.

We shall deceive ourselves less as to the method of a cure if we keep to the original term "suggestion" for all methods which depend upon the physician's directing and governing the patient. Cases where the treatment is exactly that described by these writers as persuasion have been described (see No. 10, p. 71).

In what class of war-shock cases suggestion without hypnosis yields quicker results than with hypnosis is a difficult question to decide. When no post-hypnotic influence occurs after the second or third session, I prefer to use suggestion (persuasion, re-education, etc.).

Psycho-analysis is the method for the exploration of the unconscious mind whereby the energy hitherto wasted in internal conflict is made available for the purposes of life.

Whereas any medical man can easily master the technique of hypnotism and suggestion in simple

3 *Op. cit.*

cases, psycho-analysis requires a long apprenticeship; it cannot be acquired from books alone. It will not be described here; no one is qualified to undertake psycho-analysis who has not submitted himself to the discipline of psycho-analysis by another. Like every practical art it must be learnt in the workroom. The study of the literature, important as it is, cannot replace the laboratory.

SUGGESTION AND PSYCHO-ANALYSIS.

This is the most fruitful method of treatment in war-shock. The general results of psycho-analytic knowledge are applied to the results obtained from the psychological examination of the individual patient. We aim at discovering the psycho-pathology of his symptoms (not necessarily of the whole mental state). This knowledge is used as the suggestion whilst the patient is under hypnosis (or not hypnotised). Many cases cited give evidence of the value of this method (see No. 95, p. 95). The difficulty in suggestion is to know what to suggest. When you have discovered the patient's complex this difficulty is overcome. The procedure is, of course, not new; I have practised it with a colleague in London for some time before the war, he sending me the patients for psycho-analytic examination. The discovery of what lay at the roots of the symptom was imparted to my colleague who used the information in suggestion under hypnosis.

Distraction. Sufficient has been said on this subject in the section on the soldiers' heart.

Rest. In a few cases, but in very few cases, rest, feeding, Weir-Mitchell treatment may be necessary. The type of case requiring this is a soldier who has had several mental breakdowns before the war, who is suffering from psycho-neurotic symptoms with acute psychical symptoms, such as incoherence, insomnia

want of concentration, with accompanying wasting and anæmia. I have cited a case where the psycho-neurosis only developed after enforced rest in hospital and this should serve as a hint how dangerous this treatment may be. It is most unsuitable for cases of war-shock among soldiers—it prolongs their illness and may sow the seeds of a more permanent psycho-neurosis. War-shock requires vigorous treatment and return to active life as soon as possible. The reckless way in which a rest cure and over-feeding are ordered indiscriminately for all persons suffering from any form of psycho-neurosis reveals lamentable ignorance. It is the very reverse of rational treatment. It is as if one were to prescribe digitalis off hand for every patient who complains of a pain in the left side of the chest, or opium for everyone who has abdominal symptoms. A rest cure is not merely negative or even symptomatic treatment. To a not inconsiderable number of these patients it is something positive and positively dangerous. In some obsessional cases a rest cure delivers the unfortunate victim over to an unceasing conflict with his fears without the chance of any distraction. A rest cure is a sad misreading of Hilton's advocacy of *physiological rest*. To many hysterics a rest cure affords the ideal conditions for retirement from life's duties and strengthens their motives for remaining ill.

Drugs are used, of course, in the treatment of different physical ills in the same way as the patient's wounds receive attention.

Stimulants are valueless and as the soldiers had not to buy their own drugs any value that Sanatogen or its British counterparts might have are discounted. This expensive form of quackery is useless in the Army.

The only hypnotic, used very occasionally, was one of the bromide salts. Occasionally hypnotism was

used to put patients to sleep; for wounded patients in a restless, excited condition it was often useful. Hypnotism had also a useful field in the first and second dressings of very painful wounds.

AFTER TREATMENT.

Cases with a pre-war history of psycho-neurosis are, in general, useless for the fighting ranks; they can find plenty of other useful occupations in the Army or civilian life.

The war-shock case is as suitable for return to the field as the soldier who has recovered from severe wounds.

After cure of the symptoms the patient should not be sent forthwith to the Front. Six weeks to three months after-cure is required, the first part of which time I cannot but think might be spent on furlough with his family; the latter part in one of the convalescent camps where the soldier will be gradually retrained.

Gaupp[4] found that in his hysteric patients "the symptoms returned and became intensified as soon as the words 'fit for duty' are said." It is not my experience; I imagine that Gaupp's cases had not been cured in the sense in which the word is used in this book. As I have already said, many of my patients went to the Convalescent Camp in Malta with the knowledge that this meant returning to the Front (which they did). Ten days at the least always elapsed from the time they were marked up fit for the Convalescent Camp till the time they went. In no case was there a relapse; on the contrary, the knowledge that their medical officer seemed to think them cured served to put them in better spirits.[5] In

4 I quote from Prof. Elliot Smith's summary of Gaupp's paper; *loc. cit.*, p. 17, 18.

5 These men, of course, expressed no wish to go back to the Front and all would have preferred to be sent home.

one case (No. 1) after a relapse in the sense that irritability had come on, the patient begged me to send him to the Camp as soon as he got better, which I did with the happiest results. Another patient (No. 32) also got moody by being unavoidably detained in hospital after he was well.

The Uncured. If properly treated the number of uncured cases will be small; my figures give 3 per cent., but this number could be reduced. It includes No. 62, a case of enuresis which had existed from childhood, and was not in itself a disease totally disabling the patient either from service in the Army or civil occupation. (He had always earned a living before the war.) The other case of mutism will certainly recover his speech—probably he recovered it on reaching England. The third case (No. 84) is probably a case who will get well with a year's change and rest.

No patient should be discharged from the Army till cured. It is cruel to send these men back into civil life, unless they have a good post, or a small pension. The hopeless cases, who are not likely to recover whilst in the Service, may perhaps be bribed into improvement by an understanding that as soon as they are better they will be discharged. Suitable employment should be found for them before they leave the Service.

From every point of view an early and adequate treatment of these cases is imperative; many of the patients, if discharged uncured, will sink into chronic invalidism. The artisan who feels himself unable to continue his job, even though he have a small pension, is, with the necessary limitation of his interests, a misery to himself and to his family.

CHAPTER VIII

SUMMARY OF CONCLUSIONS

(1) WAR-SHOCK is hysteria occurring in a person free from hereditary or personal psycho-neurotic antecedents, but with a mind more responsive to psychical stimulus than the normal.

(2) The wrenching from the customary calling and life, the new discipline, the peculiar and terrible mental strain of modern war-conditions acting upon this sensitive mind determine the disease among soldiers.

(3) In 100 consecutive cases of psycho-neurosis 70 per cent. correspond to this description; 30 per cent. have neuropathic antecedents, hereditary or personal; the latter correspond more closely with the psycho-neuroses seen in civil life.

(4) Shell-shock, gas-poisoning, or other physical injuries do not cause the disease. The symptoms are protean—palsies, analgesia, amblyopia, mutism, deafness, affections of the vegetative system such as the soldier's heart, vomiting, diarrhœa, insomnia, loss of memory, somnambulism, phobias and obsessions of all kinds.

(5) These symptoms are the result of mental conflicts or other mental phenomena; all the symptoms can be understood in terms of the mind without any reference to physio-pathology.

(6) The psycho-pathology of war-shock is that of

the psycho-neuroses, and the mechanisms those discovered by Freud in hysteria.

(7) War-shock is not a new disease ; it is a variety of hysteria where the one factor (the psychic trauma) is overwhelmingly large in relation to the second factor (predisposition); it is separated from non war-shock cases in degree, not in essence.

(8) The treatment *par excellence* is hypnotic suggestion. The suggestion by preference being directed to the complex as determined from the psychological examination and general psycho-analytic conclusions.

(9) 91·5 per cent. of cases of war-shock were cured by this method and 8·5 per cent. improved. Of soldiers with previous neuropathic antecedents, who form only a third of the total number, 62 per cent. were cured ; 27·6 per cent. improve ; and 10·4 per cent. are unaffected. Cure is very rapidly effected ; most cases are well in less than two weeks ; some in a few minutes or hours.

(10) The usual objections to hypnotic suggestion do not apply to war-shock by reason of the absence of neuropathic antecedents.

(11) All methods of treatment, other than psycho-analysis, are based on suggestion ; including "spontaneous recovery," persuasion, reasoning, symptomatic treatment, electrotherapy, etc. The objection to these indirect forms of suggestion is that they are less effective (more uncertain and less rapid) than suggestion under hypnosis.

(12) The earlier the patients are treated by this method the better.

(13) The majority of war-shock patients so cured can return to the Front in three to six months.

(14) Cases of "functional" disease should not be discharged from the Army until cured.

APPENDIX

SUMMARY OF 100 CASES

Column 2. + = Neuropathic antecedents, family or personal.
— = No " " "
Column 5. = Duration of symptoms in weeks = w ; months = m ; years = y.
Column 6. = Page in book where case is described.
Column 7. = Shell-explosion, wound, or other physical injury as immediate antecedent ; — = no antecedent physical trauma.

1	2	3	4	5	6	7	8	9	10
No.	Previous History.	Age.	Army Service.	Duration of symptoms till treatment began.	Page.	Following shell-explosion, wound, etc., or no previous injury or disease.	Chief Symptoms.	Treatment.	Result.
1	—	22	1 5/12 y.	—	22	Tissue atrophy.	Left hemianalgesia, atrophy of subcutaneous tissue.	Hypnotic suggestion.	Cured.
2	—	28	7 5/12 y.	9 m.	23	Gas.	Left hemianalgesia, anæsthesia headache, myopic astigmatism.	" "	Cured.
3	—	37	18 y.	9 m.	21	Shrapnel wound, chest.	Hyperæsthesia of scar, analgesia elsewhere.	" "	Cured.
4	—	27	5/12 y.	2 m.	—	Operation.	Hyperæsthesia of scar.	" "	Improved.
5	—	22	1 y.	13 w.	—	Fall.	Hyperæsthesia of back, analgesia lower limbs, right above knee, left below knee.	" "	Cured.
6	—	28	2 y.	3 m.	—	—	Pain along left sciatic nerve, "slipper" anæsthesia.	" "	Cured.
7	—	25	5/12 y.	7 w.	—	Fall.	Pleurodynia, pain in back, insomnia.	" "	Cured.
8	—	23	1 5/12 y.	3 w.	—	Operation.	Pain in breast following removal of adenoma.	" "	Cured.

9	—	36	1¼ y.	2 m.	63	Shell-explosion.	Paraplegia, analgesia-anaesthesia legs, pain and rigid back. Took part in Boer War.	Hypnotic suggestion.	Improved.
10	—	21	2 y.	2 m.	71	Frostbite.	Paraplegia, "stocking" analgesia.	Suggestion.	Cured.
11	+	22	1½ y.	6 w.	—	—	Paraplegia, analgesia legs, pain in back.	Hypnotic suggestion.	Cured.
12	—	20	1 y.	3 m.	73	—	Paraplegia, analgesia lower limbs.	,, ,,	Cured.
13	—	28	½ y.	9 w.	67	Frostbite.	Paraplegia.	,, ,,	Cured.
14	—	22	1 y.	3 m.	—	Shell-explosion.	Paraplegia, analgesia lower limbs to mid third of thigh. Three fits.	,, ,,	Cured.
15	—	25	1/7 y.	5 w.	—	—	Paraplegia, tremors of legs, "stocking" analgesia, depression, insomnia.	,, ,,	Cured.
16	—	24	1/6 y.	7 w.	—	S.W. right leg.	Paresis of both legs, "wader" analgesia.	,, ,,	Cured.
17	—	22	1/7 y.	4 w.	—	—	Paraplegia, "wader" anaesthesia and analgesia.	,, ,,	Cured.
18	—	23	1½ y.	3 m.	—	Trench digging.	Paraplegia, "stocking" analgesia.	,, ,,	Cured.
19	—	31	1½ y.	2 m.	25	Neuralgia.	Paresis lower limbs. Hemianalgesia, etc., left side and face. Headache.	,, ,,	Cured.
20	—	21	4 y.	4 m.	48	S.W. left head.	Left hemiplegia and hemianalgesia, fits, metal in skull.	,, ,,	Cured.
21	—	36	15 y.	1 m.	24	—	Left hemiplegia, hemianalgesia, etc., mutism.	,, ,,	Cured.
22	+	23	6 y.	2 m.	52	S.W. left elbow.	Contracture left elbow, non-extension of fingers, analgesia, etc.	,, ,,	Cured.

1	2	3	4	5	6	7	8	9	10
No.	Previous History.	Age.	Army Service.	Duration of symptoms till treatment began.	Page.	Following shell-explosion, wound, etc., or no previous injury or disease.	Chief Symptoms.	Treatment.	Result.
23	—	21	1 y.	5 w.	25	S.W. right head.	Drop-wrist left, "glove" analgesia, paratyphoid later.	Hypnotic suggestion.	Cured.
24	—	23	$\frac{11}{12}$ y.	2 m.	58	Bayonet wounds.	Right *main en griffe*, hemi-analgesia, etc. (left-handed person).	,, ,,	Cured.
25	—	35	7 y.	$1\frac{5}{12}$ y.	30	S.W. chest.	Paresis right hand, analgesia, etc. Stammer not entirely cured.	,,	Cured.
26	+	34	16 y.	9 w.	74	S.W. left head.	Paresis right hand, "glove" analgesia, fits. Ambidextrous.	,, ,,	Cured.
27	—	26	2 y.	3 m.	—	Fall.	Rigidity. no movement left shoulder.	,, ,,	Cured.
28	+	30	$1\frac{6}{12}$ y.	2 m.	—	Accident.	Right drop-wrist, "glove" analgesia.	,, ,,	Cured.
29	—	46	14 y.	5 m.	—	—	Paresis right hand, analgesia.	,, ,,	Cured.
30	—	20	1 y.	1 m.	—	S.W. left hand.	Paresis left hand, analgesia of same.	,, ,,	Cured.
31	—	24	$1\frac{5}{12}$ y.	5 w.	51	—	Left drop-wrist, "glove" analgesia, etc.	,, ,,	Cured.
32	—	21	$1\frac{6}{12}$ y.	7 w.	26	—	Contracture and pain left knee.	,, ,,	Cured.
33	—	37	13 y.	1 m.	27	Accident.	Astasia-abasia, tic face and hands, hyperacousis, insomnia, etc.	,, ,,	Cured

34	—	38	1 y.	6 w.	—	Accident.	Astasia-abasia, analgesia left lower limb.	Hypnotic suggestion.	Cured.
35	—	23	$\frac{6}{12}$ y.	3 w.	71	Shell-explosion.	Deaf mute, analgesia left.	Anæsthetic ,,	Cured.
36	—	25	1 y.	4 w.	70	,,	Deaf mute.	,, ,,	Cured.
37	—	27	1 y.	5 w.	29	—	Deaf mute, "collar" analgesia.	,, ,,	Cured.
38	—	25	$1\frac{2}{12}$ y.	—	28	Shell-explosion.	Deaf mutism.	,, ,,	Cured.
39	+	36	$\frac{10}{12}$ y.	6 w.	69	,,	Mutism.	,, ,,	Cured.
40	—	19	$\frac{9}{12}$ y.	5 w.	29	S.W. leg.	Mutism.	Hypnotic ,,	Cured.
41	—	25	$\frac{8}{12}$ y.	10 w.	—	—	Mutism.	,, ,,	Cured.
42	+	23	$1\frac{6}{12}$ y.	10 w.	137	Shell-explosion.	Mutism.	,, ,,	Not cured.
43	+	21	$1\frac{6}{12}$ y.	2 m.	64	Kick on jaw.	Recurrent Mutism.	,, ,,	Cured.
44	+	20	3 y.	1 m.	30	Shell-explosion.	Aphonia.	,, ,,	Cured.
45	+	22	$\frac{8}{12}$ y.	9 w.	—	—	Aphonia.	Anæsthetic ,,	Cured.
46	—	44	12 y.	2 m.	30	Typhoid.	Aphonia.	Suggestion.	Cured.
47	—	24	6 y.	3 m.	30	—	Stammer, tremors of hands, tachycardia.	Hypnotic suggestion.	Improved.
48	—	25	—	—	30	Torpedo explosion.	Stammer.	For diagnosis.	—
49	—	20	1 y.	2 w.	37	Shell-explosion.	Deafness, "collar" analgesia.	Suggestion.	Cured.
50	+	27	$\frac{6}{12}$ y.	2 m.	—	—	Deafness, paraplegia, analgesia legs, pain in back.	Hypnotic suggestion.	Cured.
51	+	21	1 y.	—	—	—	Functional deafness added to deafness of organic basis.	,, .	Improved.
52	+	22	1 y.	15 days.	35	Shell-explosion.	Amblyopia, left paraplegia, left-sided hemianalgesia, etc.	,, ,,	Cured.
53	—	20	1 y.	6 w.	—	—	Amblyopia right eye.	,, ,,	Cured.
54	—	19	1 y.	2 m.	68	Sniping.	Amblyopia right eye, ptosis (congenital) right eye.	,, ,,	Cured.
55	—	40	16 y.	15 y. 10 m.	32	Shell; slight injury.	Double amblyopia (hypermetropic astigmatism).	,, ,,	Cured.
56	—	25	1 y.	5 w.	33	—	Amblyopia double.	,, ,,	Cured.
57	—	29	$1\frac{4}{12}$ y.	15 w.	—	Accident.	Amblyopia right eye.	,, ,,	Cured.
58	—	20	$2\frac{2}{12}$ y.	3 m.	—	S.W. right eyelid.	Amblyopia right eye.	,, ,,	Cured.

1	2	3	4	5	6	7	8	9	10
No.	Previous History.	Age.	Army Service.	Duration of symptoms till treatment began.	Page.	Following shell-explosion, wound, etc., or no previous injury or disease.	Chief Symptoms.	Treatment.	Result.
59	—	19	1 3/12 y.	2 m.	39	Blepharitis.	Amblyopia, blinking of eyes.	Suggestion.	Cured.
60	—	26	5 y.	5 w.	38	Shell-explosion.	Tic lower jaw, hyperthyroidism, vaso-motor symptoms	Hypnotic suggestion.	Cured.
61	—	30	1 1/12 y.	4 w.	—	—	Tic left face, left hemianalgesia, amblyopia.	,, ,,	Cured.
62	+	20	1 1/12 y.	Childhood	42	—	Enuresis.	,, ,,	Not cured.
63	—	27	2 y.	9 m.	42	—	Enuresis.	,, ,,	Cured.
64	—	28	1 3/12 y.	10 w.	60	—	Hysterical vomiting, indigestion.	,, ,,	Cured.
65	+	28	1 3/12 y.	6 m.	41	—	Hysterical vomiting, no wasting.	,, ,,	Cured.
66	—	25	1 3/12 y.	4 m.	44	—	Hysterical vomiting, abdominal pains, tremors of hands.	,, ,,	Cured.
67	—	23	1 1/12 y.	5 w.	—	Shell-explosion.	"Soldier's heart," depression, insomnia, etc.	,, ,,	Cured.
68	+	23	1/12 y.	3 w.	45	Shell-explosion.	"Soldier's heart," insomnia, phantasies, exhaustion.	,, ,,	Cured.
69	+	32	8/12 y.	5-6 w.	—	—	"Soldier's heart," exhaustion, tremors of limbs, left hemianalgesia.	,, ,,	Cured.
70	—	31	1 1/12 y.	3 m.	46	—	"Soldier's heart," exhaustion, backache, hyperthyroidism, tremors of both legs.	,, ,,	Cured.
71	—	35	1 7/12 y.	10 w.	—	—	"Soldier's heart," exhaustion, etc., hyperthyroidism.	,, ,,	Cured.

72	+	19	1½ y.	7 m.		Fall.	Headache, total analgesia	Hypnotic suggestion.	Cured.
73	—	31	1½ y.	4 m.		Fall.	Headache, vertigo.	,, ,,	Cured.
74	—	15	½ y.	4 m.	—	Kick.	Vertigo, insomnia.	,, ,,	Cured.
75		20	1½ y.	3 days.	119	—	Fits.	For diagnosis.	—
76	—	23	3 y.	5 w.	40	S.W. left leg.	Ganser twilight state.	Hypnotic suggestion.	Cured.
77	+	31	1½ y.	1 y.	39, 86	Shelled in a hospital.	Somnambulism, left hemianæsthesia, tic, etc.	Psycho-analysis.	Improved.
78	+	21	½ y.	3 w.	—	Buried after shell.	Autopsychic amnesia	Hypnotic suggestion.	Cured.
79	—	18	1 y.	6 w.	73	—	Loss of memory 6 weeks, fugues.	,, ,,	Cured.
80	—	27	8 y.	3 m.	—	—	Obsessions, anxiety, insomnia, etc.	Suggestion.	Improved.
81	+	32	7 y.	5 m.	—	—	Somnambulism, tremors of hands, agoraphobia.	Psycho-analysis.	Cured.
82	+	27	½ y.	2 w.	—	Shell-explosion.	Phobias, fear of "worms in body," etc., hyperthyroidism, vaso-motor symptoms.	Hypnotic suggestion.	Improved.
83	—	25	1 y.	2 m.	—	—	Terrifying dreams and visions, hyperthyroidism, vaso-motor symptoms.	,, ,,	Cured.
84	+	34	1½ y.	3 m.	79	—	Fear of going mad, exhaustion, vaso-motor symptoms, stammers.	Change and rest.	Not cured.
85	—	35	1½ y.	2 m.	—	S.W. face.	Analgesia left face, emissions, fear of impotency, vaso-motor symptoms, heart, hyperthyroidism.	Hypnotic suggestion	Cured.
86	+	33	1½ y.	3 m.	—	—	Fear of fear, exhaustion, vaso-motor symptoms, hyperthyroidism.	,, ,,	Cured.
87	—	27	1½ y.	2 m.	—	—	Agoraphobia, hyperthyroidism, vaso-motor symptoms.	,, ,,	Improved.
88	—	24	1½ y.	1 y.	—	Shell-explosion.	Fear of fear, vaso-motor symptoms, tremors of hands.	,, ,,	Cured.

1	2	3	4	5	6	7	8	9	10
No.	Previous History.	Age.	Army Service.	Duration of symptoms till treatment began.	Page.	Following shell-explosion, wound, etc., or no previous injury or disease.	Chief Symptoms.	Treatment.	Result.
89	—	43	22 y.	4 m.	—	Shell-explosion.	Fear of failure in duty, vaso-motor symptoms.	Hypnotic suggestion.	Cured.
90	—	34	1 y.	3 w.	—	—	Sexual phobias, "Soldier's heart."	,, ,,	Cured.
91	—	31	1 6/12 y.	2 m.	—	—	Stammers, tremors, vague fears.	Suggestion.	Improved
92		24	3 y.	5 m.	—	Shell-explosion.	Abulia, exhaustion, analgesia left leg, vaso-motor symptoms.	Hypnotic suggestion.	Cured.
93		23	6/12 y.	4 w.	—	—	Fear of not responding to call, analgesia both legs, hyperthyroidism, vaso-motor.	,, ,,	Cured.
94	+	38	6/12 y.	2 m.	—	—	Abulia, vaso-motor symptoms.	,, ,,	Cured.
95	+	27	4/12 y.	6 w.	95	Bombardment.	Collecting mania, fear, insomnia, exhaustion, bi-sexuality.	,, ,,	Improved
96	+	34	14 y.	1 y.	—	—	Obsessions, phobias.	Psycho-analysis.	Improved.
97	+	33	13 y.	—	—	—	Obsessions, megalomania, exhaustion, insomnia (varying).	Diagnosis.	—
98	+	45	18 y.	—	—	—	Obsessions, fear of inadequacy, insomnia.	Rest and change.	Improved.
99	+	29	6/12 y.	5 m.	107	—	Arithmomania, etc., almost total analgesia.	Psycho-analysis.	Improved.
100	+	28	1 6/12 y.	4 m.	100	—	Indecision, doubt, insomnia, unreality of world, etc.	,, ,,	Improved.

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